THE UNIVERSITY OF HULL

CLIENTS' REPORTS OF THE WORK OF HEALTH VISITORS IN THE CHILD HEALTH CLINIC AND DURING HOME VISITS

being a Thesis submitted for the degree of

Doctor of Philosophy

in the University of Hull

by

Caroline Margaret Coatsworth Plews,
BA (Hons) University of Essex,
MA University of Leeds

January 2001

ABSTRACT

This study examines clients' reports of aspects of a single child health clinic visit and of a home visit by the health visitor. There are two foci of the thesis. First: recall; value and use of the advice/information selected by the client as the most important; second, an exploration of the meaning of support identified by some clients.

Seven health visitors participated in the research, which incorporated two studies. In the first study, the researcher observed the content of discussions between 100 clients and the health visitor in child health clinics. These clients were then interviewed at home and asked questions about the advice/information received from the health visitor during their previous visit to the child health clinic.

For the second study, information was recorded by the health visitor describing the content of 149 home visits. Clients were interviewed at home and asked similar questions regarding advice/information received from the health visitor. In addition, those clients who described receiving support were asked to describe the meaning to them of this aspect of the visit.

Data analysis for both studies included descriptive and inferential statistics and content analysis.

Findings from both studies indicate that recall of advice/information is related to the amount of advice/information given to the client. This may have implications for the amount of advice/information that health visitors are encouraged to provide.

Advice/information received from the health visitor was generally valued and used by the mothers in both studies. Clients appeared most likely to be dissatisfied when topics had been raised which they had no interest in discussing. It is suggested that that there may be correspondence between some clients' descriptions of support, and taxonomies of social support found in social support literature. An exploration of health visiting work employing the concepts of social support is recommended.

ACKNOWLEDGEMENTS

I would like to thank my supervisors, Professor Rosamund Bryar and Professor José Closs, for their rigorous academic guidance and personal kindness during the life of this study. To the health visitors for their interest and commitment which underpinned this study. To Northern and Yorkshire Region, the English National Board and Yorkshire Primary Care Research Network for their financial assistance. To Corinna Petre for formatting and proof reading the final script. To my husband, Rob Newell for his irreplaceable humour, patience and support.

Finally, my thanks to all the clients who gave their time to share their experience of health visiting.

CONTENTS

FIGURES

TABLES

FREQUENTLY USED ABBREVIATIONS

Term	Abbreviations
Health visitor	HV
Child health Clinic	CHC
Observation schedule	R1
Child health clinic visit interview schedule	R2
Health visitor questionnaire	HV1
Home visit interview schedule	R3
Clinic information sheet	C1
Consent form - CHC visit	C2
Consent form - home visit	C3
Consent form - audiotaping	C4

Anonymity

Names of participating health visitors, clients and family members have been changed.

CHAPTER 1

INTRODUCTION TO THE THESIS

Section 1.1 Background to the study

The impetus for this thesis arose from my clinical experience as a health visitor (HV). As a practitioner I was familiar with debates within and outside health visiting regarding the efficacy of the role and the possible ways it might develop (Barker and Percy, 1991; Williams, 1992).

Such debates were encouraged by the interest within the National Health Service (NHS) in clinical activity based on evidence of effectiveness. Traynor noted (1993, p 217): 'It was not enough to busy on honourable business' and suggested a need for health visiting to 'demonstrate its affordability and effectiveness'.

My desire to develop research skills led to a proposal for an investigation into health visiting. My own professional interest regarding the impact of health visiting and the national drive to develop nursing, midwifery and health visiting outcomes led me to focus on examining the contribution to an individual's well-being made by the HV. Lightfoot commented (1994, p 20):

> *'It is still not proven in any systematic and visible way that health visiting activity makes a difference to people's health. Health visitors themselves may be convinced, but much of the evidence for this belief remains internalised and is neither made explicit nor generally understood by outsiders to the profession.'*

A possible approach to making health visiting activity visible was to use clients' reports. At the time (1995) there was a growing acceptance that clients' perspectives of services were an important and useful means of evaluating services (Calnan, 1988), and this is still the case (DoH, 2000).

The majority of HVs' roles remained centred on home visits and child health clinics (CHCs). Therefore it seemed appropriate to select these two activities as foci for the investigation. Client reports had been utilised before in research about health visiting. However, many studies provided general comments about content with little understanding about how, if at all, these discussion were recalled, used or valued by the client. This necessarily limited their usefulness in confirming or denying HVs' contribution to their clients' well-being.

I therefore decided to ask more specific questions of clients about elements of their discussions with HVs. One study would focus on a CHC discussion and the other on a home visit. By interviewing clients approximately a week after their CHC or home visit, I hoped the client could make visible the contribution (or otherwise) arising from the discussion, to her, or her family's, well-being.

1.1.2 Organisation of the thesis

Chapter two is a literature review of home visits by British HVs. It is noted in the chapter that studies which examine the process of health visiting may be limited in their ability to describe the outcome of HV interventions. Problems are discussed regarding previous consumer studies which provide limited reporting of clients' perspectives of home visits. Chapter three reviews the work of the HV in the CHC. It is observed that despite the continuous association of HVs with CHCs, it is the *medical* services provided by CHCs which are the frequent focus for research. It is argued that the frequency of attendances at CHC suggests an interest by the client in elements of the CHC service other than medical services. However, previous studies leave unclear the extent to which the *health visitor* is a reason for clients using CHCs.

Chapter four outlines the aims and the design of the two studies. Data collection and analysis approaches included both quantitative and qualitative methods. The appropriateness of combining both methods within a study is discussed.

Chapter five reports the quantitative findings from the CHC including: topics discussed, topics recalled by clients, examination of any association between client and visit characteristics and client recall. Chapter six continues the report of findings from the

CHC, describing qualitative reports from clients about aspects of their discussion with the HV. Chapter seven discusses quantitative and qualitative findings from the CHC study.

Chapter eight reports the quantitative findings from home visits including: topics discussed, topics recalled by clients, examination of any association between client and visit characteristics and client recall. Chapter nine describes qualitative information of the advice/information discussed between health visitor and client during home visits. Chapter ten continues the qualitative findings, reporting participants' descriptions of support received from HVs by those clients who identified this as a feature of the HVs' visit. Chapter eleven brings together and discusses the quantitative and qualitative findings from the home visit study.

Chapter twelve discusses the implications of the two studies for health visiting education, practice, management and research and presents recommendations from the study.

CHAPTER 2

LITERATURE REVIEW OF THE WORK OF THE HEALTH VISITOR DURING HOME VISITS

Section 2.1 Introduction

This literature review examines the impact of the HV's work with clients during home visits.

Home visits have been a major focus of health visiting activity. Professional concerns, government policies and research imperatives contribute to an interest in the benefit that accrues from such work. The first section briefly outlines these issues in order to provide a context for the review. Sections 2-6 discuss studies which have described the work of HVs during home visits. Section 7 provides an overview of the concept of support and the final section discusses the findings of the chapter and provides the rationale for the current investigation.

2.1.1 Search method

Several sources of literature were consulted during the study and these are described below.

Computerised databases

A formal search was carried out several times during the study. The following computerised citation databases were examined:

ASSIA	1987 - 2000
Cinahl	1983 - 2000
Dissertation abstracts	1988 - 2000
Medline	1966 - 2000

The search employed the following keywords, which were also used in combined searches:

advice

client's perspectives

consumer perspectives

health visit*

home visit*

information

mother's perspectives

* = truncation, to find all words based on a root (Smeaton, 2000)

Only papers which referred to British health visiting were included for review. There are other roles similar to health visiting and public health nursing in a number of countries but there is huge variety in their responsibilities, client groups and programmes of work. As the focus of this study was on British health visiting it was not appropriate to consider literature which described foreign community nursing roles. Where the title indicated that the paper was irrelevant to the study, it was discarded. Abstracts from all other papers were examined. Where the abstract was relevant, or when there was insufficient detail to ascertain its value, papers were obtained. References found from the examination of papers were obtained where the title indicated relevance to the study, or there was insufficient detail to ascertain its relevance.

Section 2.2 The work of the health visitor and home visiting

This section outlines the role of the HV and demonstrates that the home visit is a major part of that role. The aim of home visits and the traditional client group is described. Four main issues are raised which bear on the current investigation. First, uncertainty about the benefits of routine home visiting provided by British HVs (e.g. Audit Commission, 1994; Roberts, 1996b). Second, debate within the profession that argues for the development of work at community rather than individual level (e.g. Lowe, 1988; Dalziel, 1992). Third government initiatives, which call for an enhanced role for HVs particularly in their work of offering advice and support to parents (DoH, 1998b; 1998c; 1999a). Finally, the need to develop knowledge about nursing interventions (DoH, 1999c). These issues are described in order to present the rationale for this thesis's examination of the work carried out by the HV during home visits.

However, any discussion about evaluation of health visiting must acknowledge the recent contribution of Elkan et al. (2000), regarding *home visiting*. This section will begin with an examination of this review in order to place the contribution of this thesis within context.

2.2.1 'The effectiveness of domiciliary visiting; a systematic review of international studies and selective review of the British literature' - an overview

The interest at a national level regarding the usefulness of home visiting is demonstrated by the funding of this review. The primary objective of the research team was to assess the existing literature regarding the effectiveness and cost-effectiveness of domiciliary health visiting. The authors note (Elkan et al., 2000, p 1):

> '*The prime expectation of any health visiting intervention is that it should bring about improved outcomes.*'

The review is divided into three parts: studies which predominantly adopt the randomised controlled trial (RCT) as a methodological framework; a selective review of British health visiting literature and implications for practice and recommendations. The majority of studies (n = 85) reported services to parents with young children, while a further 17 examined home visits to older people and/or their carers.

The authors concluded home visiting was shown to be effective in several areas concerned with parents and children and older people and their carers. However, demonstrating effectiveness on a number of outcomes for home visiting programmes appears to be only the beginning of demonstrating effective *British health visiting practice.*

Part 1 of the review which is concerned with demonstrating outcomes for home visiting, relies predominately on American research. In their reviews of the different research areas (Elkan et al., p 43) the authors only once say that the review provides evidence that *British health visitors* can be successful in a particular intervention (the detection and management of postnatal depression). In their recommendations the authors note the need for future research and to establish a substantial *British* knowledge base (Elkan et al., 2000).

The review is important and informative in the enormous amount of information it provides on various intervention programmes and the discussion of methodological problems, including guidance to strengthen future research programmes. This knowledge may inform development of research and models of practice for British health visiting in the future but is limited in the comment it provides regarding *current* British health visiting practice. Studies using British HVs involve *specific* types of client group (e.g. mothers with children with behavioural problems) and *experimental* interventions where the control is often routine health visiting practice. Consequently, these studies are limited in their ability to describe or evaluate *routine* home visits by HVs.

In the second part of the review the authors comment on the problem of lack of evaluative studies that specifically examine British health visiting practice. They note that the brief of their commissioned research was to investigate effectiveness and cost effectiveness, which limited the possible inclusion criteria and therefore the type of study including most of the British literature on health visiting. Areas of home visiting discussed in the second part of the review are shown in Figure 2.2.1.

Figure 2.2.1: A review of specific types of home visits by health visitors (Elkan et al., 2000)

Health visiting with:
Traveller families
Homeless families
With families in poverty
The elderly
Families with special needs
Mothers with postnatal depression
Health visiting services and the prevention of Sudden Infant Death Syndrome
Home visiting by community mothers
Health visiting and child protection
Health visitors and unintentional injury in childhood
Health visiting and the uptake of services
Other aspects of the HV's domiciliary role:
Increasing the uptake of breast screening
Developing services for families with members with HIV
Health visiting and domestic violence

The majority of the discussion (20 pages) about the home visits literature refers to the issues shown in Figure 2.1.1. By contrast discussion about 'routine' home visits is covered

in just over two pages. At the beginning of the chapter discussing routine health visiting the authors (Elkan et al., 2000, p 226) observe:

> *'Perhaps the greatest irony ... from the preceding papers is that they are concerned almost exclusively with a variety of "problems" with which health visitors become involved. Yet, traditionally, the health visitor has been a generic worker whose primary brief has been the universal visiting of all families with children.'*

The authors add:

> *'... many health visitors have been concerned with making explicit the nature of this generic visiting to "normal" families, and with the "problem" of proving its effectiveness.'*

In an attempt to examine evaluations of generic health visiting, the authors examined theses from 1980 - 1997 which had explored the work of HVs in routine home visits to families. A table outlining objectives, methods, sample details, outcomes and conclusions for 12 PhD and five MA/MSc's in health visiting is provided (with the significant omission of De La Cuesta, 1992). However, the table does not offer *any critique* of the studies in the way that previous studies within the review were examined. Nevertheless, the authors argue that two general lessons can be drawn from this work. First, apart from two theses (Luker, 1980; While, 1985) the studies have focused on process rather than outcomes and, in general, researchers have found that HVs have frequently been doing what they claimed (Elkan et al., 2000, p 227):

> *'... notably listening in a non directive and non authoritarian way, and giving advice appropriate to a family's circumstances.'*

Studies that provide some evidence that HVs may be directive and give advice inappropriately (Sefi, 1985; Montgomery-Robinson, 1987) are discussed briefly with the suggestion that practice may since have improved, as a result of these and other studies. As corroboration for this argument Cameron's more recent (1994) findings of HVs who

were sensitive to client's needs are cited. While Cameron's excellent study reports positive perceptions of home visits it should be remembered that the majority of analysis was carried out on 14 of 39 taped interviews. Cameron does not explain how they were selected, so there is the possibility of bias. In addition, the sample was restricted to first time mothers, most with babies between 2 - 6 months old so it is unclear whether home visits to mothers with other characteristics would produce the same findings. It *may be* that Cameron's findings reflect sensitive modern day health visiting practice but health visiting may need to argue its case more clearly. In addition, the fact that HVs are shown to be more sensitive within interactions does not necessarily imply a useful or necessary outcome for the client.

The client's perception of health visiting and home visiting is a notable absence from the review. The authors observe that out of the 85 studies which evaluated services to parents and children only 11 attempted to assess client satisfaction. They note most of the studies reported participants' views in such a perfunctory way that there was little explanatory power in the findings. Elkan et al. (2000), comment that if home visiting services are to be effective they must be acceptable to the client and therefore satisfaction should always be included in evaluation of services. A list of client satisfaction surveys (with the significant omission of McIntosh, 1986) concerned with health visiting is included in the appendix, but there is no discussion of these findings.

This systematic review provides valuable information about a variety of home visiting programmes which have been shown to be effective according to a number of outcomes. A conclusion that arises from this work is the need to describe the outcomes that arise from *British health visiting.* The authors highlight the limited knowledge base and describe the need for further research. Moreover, the previous emphasis on investigating health visiting process suggests the need to investigate outcomes. This must involve examining client perspectives, which the authors acknowledge have been neglected in the past.

2.2.2 Health visitors, health visiting and home visits

A Government report (DoH, 1998b, p 11) describes HVs as:

> '*... fully qualified nurses who take additional training covering child development, public health, psychology, sociology, health promotion and teaching...*'

The work carried out by HVs has been defined as consisting of: 'planned activities aimed at the promotion of health and the prevention of ill-health' (CETHV, 1977, p 8). Twinn (1991) suggests that these planned activities can be divided into four different domains:

- Community level work determined by epidemiological and environmental concerns
- Community level initiatives responding to community defined needs and perspectives
- Working with individuals in a facilitative manner using principles of empowerment
- Working with individuals offering advice and information on aspects of health.

Although there is debate (e.g. Billingham, 1991) about the future direction of health visiting, working with individual clients represents the majority of current HV activity. There is evidence that much of this work involves home visiting. The centrality of home visits to health visiting practice is reported by several researchers (Clark, 1981; Robinson, 1987; While, 1989; Heritage and Sefi, 1992; Cameron, 1994). Montgomery-Robinson (1987, p 21) suggests that investigation of home visits 'should be a central research concern'.

Theoretically, HVs are trained to visit *all* sections of the population (Robertson, 1991) but research findings demonstrate that the majority of clients visited by the HV are antenatal women and mothers with pre-school children, most visiting occurring in the first year (Marris, 1971; Clark, 1981; Watson, 1981; While 1989; Carney et al., 1996). As previously stated the focus of such visits is: 'planned activities aimed at the promotion of health and the prevention of ill-health' (CETHV, 1977, p 8).

These preventive activities involve three possible levels of prevention: primary, secondary and tertiary. Primary prevention involves interventions aimed at maximising health and

preventing the occurrence of problems that might adversely affect an individual's well-being (e.g. exercise regimes, information on prevention of cot death, discussion of effect of parenting on personal relationships). Secondary prevention focuses on early detection and intervention with issues that affect well-being (e.g. developmental screening tests for children, identification of postnatal depression, debt counselling). Tertiary prevention involves ameliorating the effect of an established condition (e.g. development of strategies to cope with the role of carer, chronic illness, unemployment).

The tradition of health visiting activity with families with pre-school children has been challenged (e.g. Symonds, 1993; Willis, 1997). It has been argued that HVs should develop community approaches which recognise and attempt to alter socio-economic determinants of health rather then focusing on behavioural and attitudinal change at an individual level (e.g. Forester, 1982; Craig, 1995). Notwithstanding this debate and the development of initiatives working at a population level (Community Interest Group, 1998) health visiting apparently still remains at this time rooted in work with families with children under five years old years of age (Craig, 1998). This work has received a fresh impetus arising from government interest in increasing the help and support given to parents and children (DoH, 1998b; 1998c). A recent speech by public health minister Yvette Cooper, emphasised government concern with improving children's health and the importance of the health visiting contribution (Cooper, 2000).

Government concern is predicated on the belief that families are under stress and the state has a responsibility to provide support for parents in order that they can better support their children (DoH, 1998b, p 6):

> *'All parents need support with their children's health, education and welfare, and many also want advice and guidance on how to bring up their children.'*

As a consequence, the government has provided £540 million over three years to the Sure Start programme which will fund schemes to support disadvantaged families (DoH, 1998b). In addition, an expanded role for the HV is amongst the suggested initiatives to improve parenting support. The report argues that this would involve a move from dealing with problems to a proactive role of *preventing* problems. Recognition is given to the

work already done by HVs with families, but it is suggested an enhanced role would include not only more group work for but also *increased* home visiting after the birth of a baby. This has some interest because it has been suggested by others that the benefit of health visiting has not been established (e.g. Audit Commission, 1994; DoH, 1996).

The Audit Commission (1994) suggested that several questions required answers in relation to health visiting. These questions included exploring what HVs do and what benefits result from their activity. Roberts (1996a; 1996b) argues that health visiting is expressed in such a way as to be untestable and proposes a radical reformation of the role. The author suggests that HVs become nurse practitioners and assume some of the responsibilities carried out by doctors. This would entail refocusing activity on delivering clinical care rather than the more nebulous pursuit of health promotion.

The need for clarification of the role of health visiting is reflected in a review of primary care nursing research (DoH, 1999c). The Primary Care Nursing Annex refers to *all* community nursing in primary care as 'largely invisible' (DoH, 1999c, p 32) and in addition to other suggestions calls for: 'descriptive research in primary care nursing to underpin nursing proactive interventions' (DoH, 1999c, p 32). The drive for increased knowledge about nursing interventions is also apparent in government proposals for modernising the NHS (DoH, 1997; 1999b; 2000b).

Increasing quality of the service users receive is a major theme, and includes the development of effective and efficient practice. However, in addition to dimensions of effectiveness and efficiency, users' perspectives of their experience are recognised as a valid and important component of any future evaluation of service delivery (DoH, 1997; 1998a). Further, the theme of development of effective practice and responsiveness to users' views is *specifically* acknowledged in relation to all community nursing including health visiting (DoH, 1999c).

Summary

The drive to develop effective practice within the NHS includes primary care nursing, to which health visiting is major contributor. The 'invisibility' of primary care nursing would appear particularly applicable to health visiting given that concerns with its evidence base

which have led some commentators to query whether health visiting should continue to exist in its current form (Roberts, 1996a). In addition, professional debate within health visiting has suggested that promotion of health might be better carried out at a population level rather than with individuals (e.g. Forester, 1982; Craig, 1995). However, others argue for an *extension* of the traditional HV's role including additional home visits to families (DoH, 1998b; 1998c). Therefore, the rationale for the home visiting literature review arises from different perspectives held by stakeholders about the activities that should comprise the role of the HV. Home visits have been shown to be a key health visiting activity. Therefore it is timely to examine the literature to attempt to establish whether home visits do promote the health of individuals.

Section 2.3 The work of the health visitor during home visits

The work of HVs during home visits has been described from five perspectives: accounts of the process of health visiting (e.g. Chalmers, 1990; Cowley 1991), reports provided by HVs (e.g. Marris, 1971; Clark, 1973), observation of visits (Watson, 1981; Kendall, 1991), analysis of audiotaped home visit discussions (e.g. Clark 1985; Montgomery-Robinson, 1987; Kendall, 1991), and clients' accounts (e.g. Moss et al., 1986; Machen, 1993). This section examines the first four approaches and discusses some of the methodological problems associated with these studies. Studies of clients' accounts are reported in Section 2.4. and Section 2.5.

2.3.1 Health visitors' accounts of the process of health visiting

It is suggested by Robinson (1982) that HVs should develop a relationship orientated rather than a problem orientated approach in their work. This author argues that attempts to evaluate health visiting may focus on the use of quantitative measures which identify outcomes arising from *problem* orientated health visiting. This may result in ignoring the 'intangible elements' of health visiting that arise from a relationship-centred approach which is described as *'dependent on less concrete factors such as the development of rapport or empathy'* (Robinson, 1982, p 85). Later commentators suggest research has already successfully (Campbell et al., 1995, p 29): 'demonstrated the value of the relationship in enabling and achieving positive client outcomes' [my emphasis]. A problem arises with this statement in that all the research referred to reported the perspectives of *health visitors* (Chalmers 1990; Cowley, 1991; De La Cuesta, 1992).

De la Cuesta (1992) observed interactions between HVs and clients during home visits (n = 121) and interviewed HVs (n = 21) about their interactions with clients. Her study does not describe *clients'* perspectives of these interactions. Indeed, in the complete report of the research (De La Cuesta 1992, p 343), the author states that the study contains no data from the client's perspective, focuses on the process of the service and does not attempt to evaluate the service. Therefore, the findings represent *professional* beliefs of HV/client interactions and the role of the relationships upon these interactions.

Similarly Chalmer's data were derived from interviews with 45 *health visitors* (Chalmers, 1990). The participants were asked to describe features of their work with clients with whom they felt they had had successful outcomes and clients with whom they had had little impact. One hundred and ninety cases were discussed by the HVs. The resulting data provided a detailed account from the *health visitor's* perspective of how they initiated access (Luker and Chalmers, 1990), developed a relationship (Chalmers and Luker, 1991), searched for clients' needs (Chalmers, 1993) and worked with clients (Chalmers, 1992). However, the study cannot comment on the *client's* perspective of these events.

The third study referred to by Campbell et al. (1995) also obtained data from interviews with HVs (n = 53) (Cowley, 1991). In addition, the researcher carried out non-participant observation of three HVs during one of their child health clinics and discussed three audiotaped home visits carried out by different HVs. The focus of the study was to produce a theoretical explanation of the process of health visiting. The author suggests that the complex theoretical framework generated by the data should be regarded as a *tentative* explanation. Cowley (1991, p 416) explains:

> *'It* [the theory] *is derived from a conceptual analysis of the data, and represents neither a factual description of consciously expressed opinions, nor a survey of what actually happens in practice.'* [my emphasis]

Further, the author notes (1991, p 426) that the conceptual framework may provide a logical basis from which to explain HV interventions but *cannot* show whether these interventions are effective. Caveats regarding the theoretical nature of the knowledge

arising from the study and the limitations this imposes are also apparent in a subsequent paper arising from the study (Cowley, 1995, p 283):

> *' Integrating the theoretical codes into a new framework offers a different way of looking at things and provides that which is 'new' about the theory (Glaser, 1978). A 'theory' is not a 'fact'; it is a hypothetical generalisation which remains tentative. While it may be tested, it is best evaluated by the extent to which it seems to fit and work, and whether the insights it yields can generalise to other similar situations. Thus the analysis presented here should be viewed as a potential explanation of the way health visitors may approach clients to promote health, rather than a description of what happens in practice.'*

The author's suggestion that the theory is best evaluated by the extent it seems to fit and work and whether the insights can be generalised to other similar situations raises two issues. First, it is unclear why a theory is best evaluated not by testing the theory but by seeing to what extent it seems to fit and work. Although the author apparently views this as the soundest means of evaluation this approach is not unproblematic. If a theory of practice is derived solely from the reports of HVs, assumptions based on those reports rely on the accuracy and insight of the respondents. How clinicians think they act or report they act with clients may or may not reflect *actual* practice. Even more difficult may be establishing whether how clinicians think *clients* have reacted to their intervention is actually the case.

These points are illustrated by Pearson's (1988) longitudinal study of primiparous clients' perspectives of health needs and health visiting from the antenatal period to the first nine months of the baby's life. Comparisons were made between the perspectives of HVs and their clients which suggested differences between the two groups. In considering reasons which might explain this divergence Pearson suggests that HVs' perceptions of the client's needs and the role of the HV may be affected by practical considerations such as time constraints, she observes that (Pearson, 1991, p 527):

> *'She* [HV] *may largely deny the existence of other needs to avoid the requirement to offer a service beyond her capacity.'*

This observation might suggest that clinicians do not act in isolation from competing influences and demands, of which the needs of clients are only one source. The following quotes from a HV and her client illustrate the differences that can exist between professional and user perspectives (Pearson, 1991, p 527):

> '[I've] *given her a lot of input, a lot of time ... I feel happy now she's working at it alone.'*
> (HV: case study D)

> *'I don't really feel I can relate to her very much at all ... she wouldn't be the first person I'd go to with a problem 'cos I never see her.'*
> (parent: case study D)

The differing perceptions of health visiting and client needs noted by Pearson (1991) suggest that relying solely on HV's accounts of their actions and the *apparent* resultant benefits to clients is not necessarily sufficient.

Similarly, Kendall (1991) reported differences in perceptions between clients and HVs with regard to objectives of a home visit, perceptions of health needs, perceived plan of action and perceived follow up. The study investigated client participation in health visiting and a main conclusion was that HVs did not demonstrate in practice their *stated* commitment to client participation.

Findings from Pearson (1988) and Kendall (1991) indicate a need for either corroborative accounts from clients or testing of theories of health visiting practice before claims (e.g. Campbell et al., 1995) can be made that these theories demonstrate the value of the relationship in enabling and achieving positive client outcomes. Chalmers (1991), De La Cuesta (1994) and Cowley (1995) are highly interesting, accounts of professional views of practice that offer insights and opportunity for debate and thinking about practice. They are studies which describe the process of health visiting from the perspective of the HV and are therefore limited in what they can tell us of outcomes for the client.

2.3.2 Health visitors' recordings of home visits

Four main aspects of work during home visits are provided by HVs' self reports: time taken, type of clients seen, techniques used and content of discussions. An early review of health visiting activity by Marris (1971) involved 215 HVs recording their activities for a period of two weeks. Average times taken with various groups of clients varied between 9 minutes - 24 minutes. This range of times is reflected in the findings of studies reviewed by Clark (1981). An earlier study by Clark (1973) found 28.4% of visits lasted less than 15 minutes, 50.9% took between 15 and 30 minutes, 16.9% lasted between 30 minutes and one hour and 3.4% more than one hour. The majority of clients seen were mothers with children under five although the proportion varied between studies (Marris, 1971; Clark, 1973; Clark, 1981).

Marris (1971) investigated which techniques were employed by HVs during visits. Techniques referred to three groups of activities: communication, practical procedures and referrals to other agencies. Communication was used most frequently with advice, explanation or guidance the most commonly reported activity within this category. Similarly, Clark asked participating HVs (n = 72) to record for each topic discussed one of three levels of discussion: listening and reassurance only (level 1), discussion plus some factual information (level 2), discussion plus some positive advice or teaching (level 3). Nearly 40% (39.9%) of all topics were discussed at level 1, 36.2% of topics were dealt with by level 2 and just under a fifth (19%) by advice or teaching. Generally, Clark found that the proportion of advice compared with reassurance and information was low for all topics. However, as Clark does not define these terms it is not clear what the differences might be between the categories.

In terms of content of discussion, Marris's (1971) self-completion questionnaire provided HVs with 38 preselected topics subsumed under 10 main groups (e.g. child management, health). The majority of the reporting simply refers to the main group heading and therefore provides little detail. Child management topics occupied the largest proportion of time (30%) but as the findings do not distinguish between clinic work, school work and home visits, topics discussed on domiciliary visits remains unknown.

Moreover, the reporting of time spent on topics was imprecise as Marris (1971) simply divided the length of time of the activity (e.g. home visit) by the number of topics discussed during the activity. There is no rationale for presuming that topics were accorded an equal amount of time during the discussion so that the average time attributed to each topic is somewhat spurious. Three fifths of visits (60.4%) involved between one and three topics. However, this low figure might arise due to the broad definition of topics used in the study. For example, the category 'Infant management and diet and minor health problems' includes three possible different issues. It is conceivable that a HV who had discussed sleep routines at night, introducing solid food into the child's diet and management of a child with a pyrexia might just select this one category this leading to an under reporting of topics.

The coding list for topics provided by Clark (1973) was more extensive as it included 50 items. Child issues were most frequently recorded in home visits to families with young children although other topics were also raised during many (73.6%) of these visits. In addition, the author (Clark, 1973) reported that over half (57.2%) of all topics were initiated by the HV. Clark (1973) suggests that this reflects the dominance of the HV in controlling the flow of subject matter.

The majority of studies reviewed by Clark (1981), together with her own study (Clark, 1973) and Marris (1971), incorporated self- recording of activities by HVs. Clark (1981) refers to problems inherent in such an approach of recording being affected by inaccurate recall, misunderstanding, or participants recording what they felt *ought* to have happened. Montgomery-Robinson (1987, p 13) goes further when discussing the methodological problems associated with self recording:

> '*... all the studies referred to in Clark's* [1981] *chapter relied on recall by the health visitor after the event. It is therefore difficult to assess them seriously as accounts of what actually went on during home visits.*'

The author (Montogmery-Robinson, 1987) does not make it clear whether the problem is the ability of the HV to *recall* the event or the trust the reader can have in her *recording* of the event.

2.3.3 Observer reports of home visits

One study (Watson, 1981) which avoided such problems involved the researcher collecting data by non-participant observation and therefore did not rely on the self report of HVs. During the pilot study, Watson reported over 200 topics discussed between HVs and clients. In order to facilitate data analysis thirteen topic *groups* were developed, which were used to describe the topics in the main study (see Table 2.3.1).

Table 2.3.1: Description of topics (Watson, 1981, n = 472)

Topic Group	Incidence of all topics (% of all visits n = 472)	Occurrence as main topic (% of all visits)
Services and service providers	85	17
'Illness'	79	15
'Health'	72	4
Income, finance, occupation	44	4
Housing, home situation	43	5
Infancy	43	26
Childhood	40	13
Immunisation	30	<1
Ageing and handicap	29	3
Emotional and behavioural problems	28	3
Reproduction	19	1
Accidents	18	0
Anything else	70	10

(Adapted from Watson 1981, p 199)

A topic was defined as 'main' according to the amount of time spent and therefore did not necessarily reflect the perception of *either* the HV *or* the client in terms of what constituted the most important topic discussed. The number of topics discussed during home visits was noticeably larger than recorded by Marris (1971) (see Table 2.3.2).

Table 2.3.2: Number of topics study discussed (Watson, 1981, n = 472)

Number of topics discussed	Number of visits	% of sample
1-5	13	3%
6-10	69	15%
11-20	260	55%
21+	130	28%
Total	**472**	**100%**

(Adapted from Watson, 1981 p 171)

In addition to description of topics discussed, Watson (1981) observed that the main activity by the HV in most visits was listening. This was interpreted as an indication of client participation. Watson (1981, p 170) concluded that the findings reflected: '... a professionally based service in which a striking degree of egalitarianism had been achieved'.

2.3.4 Conversational analysis of home visits

This description of an egalitarian relationship has been challenged by others' research (Montgomery-Robinson, 1985; Sefi, 1988; Kendall, 1991). Sefi (1988) analysed nine primary visits to first time mothers by five HVs. Conversational analysis showed the HVs adopted an expert role and dominated the discussions. Another study (Montgomery-Robinson, 1987), also using conversational analysis of primary visits (n = 28) reported HVs controlling aspects of the discussion. However Montogmery-Robinson also found instances where mothers introduced topics and where clients *chose* not to take the interactional initiative despite some encouragement from the HV.

A later study (Kendall, 1991) examined the perceptions of 75 clients and 16 HVs about aspects of visits. In addition, 62 transcriptions of home visits were analysed using a conversational analysis approach. This study did *not* include primary visits. Kendall found a lack of congruence between HV and client regarding the objectives of the visit, perception of the client's need, perception of plan of action, and perception of follow up arrangements. The researcher argued that mismatches between perceptions indicated a lack of participation by clients. Further, the author reported evidence of the HV controlling the agenda and process of the discussion. Kendall observed that advice giving was a main feature of the discussion but HVs rarely adopted a participative approach with the client. She notes advice given tended to support the HV's own agenda and was prescriptive and stereotyped. Montogmery-Robinson's (1987) observation that the mother might choose not to take the initiative appeared to be given some support by Kendall (1991), who observes that most mothers in her study were very acquiescent in their interaction with the HV.

These observations of the process of interaction between HV and client do not examine the *outcomes* of the interactions, but other research (Foster and Mayall, 1990) suggests that

clients resent an authoritarian approach by HVs. In addition to the rejection of the notion of an egalitarian relationship between HV and client proposed by Watson (1981), a number of objections have been raised with regard to the methodology employed by this author concerned with the process of categorisation. Montogomery-Robinson (1987, p 23) suggests two main problems with attempting to categorise HV activity:

> *'First, the category systems can in theory be reworked and the raw data (if it was recorded) re-categorised almost indefinitely. It is not possible to say that this version is the right category system or that instance of categorisation is correct ..... we may ask what were you talking about? or did she reassure you? but we do not intend to use such enquiries in anything other than a common sense fashion. Such categorisation systems are essentially lay structures and the attempt to apply scientific measurement to them is a misguided enterprise. Because of this, the second problem is inevitable: that the descriptions of health visiting produced do not retain the essential features of interaction. One essential feature of interaction, for example, is that it is untidy, complex, even on occasions confused.'* [original emphasis]

Montgomery-Robinson's objections appear, in part, due to a misunderstanding of the nature and purpose of categorisation. Categories are a method of organising and describing certain aspects of data. The fact that there are alternatives in how people may categorise is not necessarily a problem as long (as Watson does) a clear rationale is provided for the categories that *are* used. By utilising categories, detail *is* inevitably lost in condensing information. However, not all detail is essential for every purpose - again it will depend on the aim of the research.

The second objection is that categorisation erases what Montgomery-Robinson (1987) perceives as the essential features of interaction: untidiness, complexity and confusion. This 'missing element' would only matter if it is was germane to Watson's study, which it is not. Montgomery-Robinson does not describe the other essential features of health visiting or attempt to substantiate the implication in her argument that Watson's methodological approach is flawed. Consequently, these objections would seem to be

more about ideological perspectives regarding legitimate approaches to examining health visiting rather than methodological concerns.

Clark (1985) comments on the problem of lack of reliability that occurs in trying to develop categories, whether of topics discussed during a visit or other aspects of the interaction. She attempted a feasibility study using 10 transcripts of recordings of home visits made by HVs. The coding system of 51 topics used in her 1973 study was rejected as being 'too complex'. Why it was too complex, is not explained. Subsequently, a coding system was adopted in which (Clark, 1985, p 95):

> *'... subjects were grouped into eight groups and the topic within it could be distinguished by a two digit number.'*

Examination of the form in the thesis appendix reveals that there were 89 topics allocated between the eight groups so it is not clear how this list was less complex than the former. In addition, Clark devised a skill codebook of five main and two residual categories: elicit information; assess/analyse; reassure/support/inform; advise; maintain interaction and practical procedure. It is not clear what distinguishes a main from a residual category and there appears to be a category description missing.

The author, together with an HV research assistant and the research secretary coded the transcripts on two occasions but were unable to achieve more than 60% inter-rater reliability. Clark (1985, p 106) concludes that the problems experienced in the study with achieving validity and reliability were symptoms of:

> *'... more serious conceptual problems which are inherent in the quantitative approach to the analysis of health visiting practice.'*

The author outlines two problems in categorisation of health visiting activity:

- The Gestalt principle that the whole is more than the sum of its parts
- The distinction between words and their meaning

In relation to the first issue Clark (1985, p 107) explains:

> *'A tune is more than the total of its notes played separately.... It can be argued the health visitor-client interaction which constitutes health visiting practice is more than the patterns or frequencies of categories of subject matters or behaviours revealed by interaction analysis.'*

Understanding a phenomenon *may be* experienced in a gestalt of appreciating the meaningful whole but it is not the *only way* to know something. The fact that patterns and descriptions of elements of a whole are examined does not imply that the examiner does not realise that these separate elements do not represent the complete phenomenon. A problem would arise if such investigators claimed that their examination represented the *only* valid description of health visiting practice. Listening or playing a tune is a different activity from learning about the notes that contribute to hearing or playing the music.

The second problem, regarding language, concerns the reliability of coding procedures, Clark (1985, p 109) writes:

> *'... when coders are asked to categorise naturalistic conversations, even on the apparently simple dimension of subject matter, they intuitively and inevitably categorise on the basis of their own understanding* [original emphasis] *of the data before them, and the interpretations will vary from coder to coder according to their personal frame of reference and previous experience.'*

Further, she argues that coder training results in a common frame of reference between coders and therefore improvement in inter coder reliability following training may reflect the quality of training rather than the quality of the measure being used.

Whilst it is true that interpretations differ between people, on a common sense level we also have the ability to *share* the meaning of situations and language. If there was not this shared basis for understanding, daily social intercourse with others would be difficult if not impossible. Improved inter-rater reliability *may* reflect the quality of training rather than the quality of measure or it *may* be the case that the measure is adequate and that the

research team can now code the material in a similar way. Clark is raising serious and important issues but the seriousness and importance rests on the degree of error that might arise in a particular study. Clark evidently had problems with her study but this is no reason for arguing that *in principle* categorisation of content and activities should never be used to investigate health visiting practice.

Summary

Many accounts of the process of health visiting do not provide an account of *client* perceptions of process and outcomes (Chalmers, 1990; Cowley, 1991; De La Cuesta, 1992,). This is particularly pertinent because of the possibility of divergent perceptions of events between HV and client, as illustrated by other researchers (Pearson, 1988; Kendall, 1991).

Descriptions of the content of home visits (Marris, 1971; Clark, 1973; Clark, 1981; Watson, 1981) suggest a wide variety of topics discussed with the emphasis on child focused issues. Research findings (Clark, 1981; Watson, 1981; Sefi, 1985; Montgomery-Robinson, 1987; Kendall, 1991) are divided about whether interactions between HVs and clients demonstrate a non-authoritarian style by the HV.

Problems have been noted with the reliability and validity of research findings based on self reports by HVs of what they do during home visits (Clark, 1981; Watson, 1981; Clark, 1985; Montgomery-Robinson, 1987). In addition, some researchers (Clark, 1985; Montgomery-Robinson, 1987) have raised concerns as to the appropriateness of methodological approaches which involve categorisation of health visiting activity.

Examining client accounts of services received and the effect of these services is an alternative approach to examining the home visits carried out by HVs. This perspective is reported and discussed in the following two sections.

Section 2.4 Clients' accounts of the content of home visits

It has been suggested (Watson, 1981; Clark, 1985; Montgomery-Robinson, 1987) that self-reports by HVs and observation of home visits may not present an accurate picture of the content of home visits. Examining *clients'* reports of the content of home visits provides

an opportunity to compare professional accounts of services offered with client perceptions of those services. The issues of reliability raised with regard to self reporting by HVs may remain to some extent. Clients' memories may be as fallible as HVs', and clients' responses may reflect what they feel it is *appropriate* to say.

Additional problems are noted in the following studies which examine clients' reports of visits. At times the construction of the questions limits the description that a client can provide. Some studies do not differentiate between content of clinic visits and home visits. Several reports ask clients to recall details of multiple visits occurring over months or years. These issues are discussed with reference to the relevant studies.

2.4.1 Clients' reports of the content of home visits

Section 2.3 showed HV's recordings of the content of discussions covered a variety of issues primarily focused around children but also including the mother and other family members. It is of interest to see whether client accounts also reflect this breadth of health concerns. A summary of research findings that have asked clients questions about the content of home visits is shown in Table 2.4.1. The complexity of the Table highlights the difficulty of comparison between the different studies.

Table 2.4.1: Studies reporting client's description of the content of home visits

Study	Questions commenting on content of home visit	Responses from clients	
Bax et al., 1980 (n = not stated)	Most common areas for HV to have helped	Child's feeding (frequency not recorded) Arranging day care provision (frequency not recorded) Housing (frequency not recorded)	
Orr, 1980 (n = 68)	Description of recent contact with the HV	41.2 % (n = 28) had recent contact with HV, 21 mothers within the last 2 months 24 (35.3%) had made contact regarding the baby: 10 (14.7%) had made contact regarding immunisations 3 (4.4%) asked by GP to have hearing test 11 (16.2%) teething, crying and feeding difficulties 2 advice about medication for home help client 1 advice about travel immunisation 1 wanted to complain about neighbour	
McIntosh, 1986 (n = 60)	Types of useful assistance received from the HV during the study	Number of client's receiving assistance (n = 24, sample total n = 60) Infant feeding Child health problems Family Planning advice Advice on Immunisation Material assistance (supply of clothes etc.) Social problems (housing, benefits etc.) Mother's health Crying baby Home safety Unspecified Total number of responses	Number of issues 11 9 6 5 5 3 3 2 1 3 48

Study	Questions commenting on content of home visit	Responses from clients	
Moss et al., 1986 (n = 96)	Clients asked who was *most* helpful with problems they had (selected a maximum of 1 from each category to talk about)	Problem category *Feeding* 7 wks - 6 mths 6 mths - 12 mths Problem category *Day time behaviour* 7 wks - 6 mths 6 mths - 12 mths Problem category *Night time sleep* 7 wks - 6 mths 6 mths - 12 mths Particularly helpful with advice in first year	Percentage of mothers choosing HV 15% 29% 12% 5% 23% 19% 22%

Study	Questions commenting on content of home visit	Responses from clients			
Watson, 1986 (n = 101)	2 months Asked the advice HV had given them 8 months Question not noted by author 14 months Question not noted by author	2 months Feeding Bathing Clothing Immunisation Other 8 months (n = 26) Mentioned the importance of feeding and immunisation information 14 months (n = 25) No description of discussions with HV reported	Bengalis (non-English speaking) (n =28) 86% 29% 14% 61% 21% (n = 26) Mentioned the importance of feeding and immunisation information (n = 25) No description of discussions with HV reported	English speaking immigrants (n=24) 63% 21% 4% 51% 25% (n = 22) Valued 'chats' and advice (n = 22) No description of discussions with HV reported	Indigenous (n = 49) 39% 2% 2% 71% 29% (n = 48) Preferred older women as HVs (n = 46) No description of discussions with HV reported
Weatherley, 1988 (n = 50)	Does your HV give you useful information?	Author comments that overall response to a *series* of questions *including* this question was 'generally encouraging'			

Study	Questions commenting on content of home visit	Responses from clients		
Colliety, 1989 (n = 40, n = 15 [2 groups])	Clients who asked HV for help or advice (different but matched groups)	1986 study (n = 40) Child aged 3 mths Child aged 9 mths Child aged 12 mths 1988 study (n =15) Child aged 3 mths	Asked HV for advice 87% (n = 13) 100% (n = 13) 87% (n = 10) 87% (n = 13)	Felt it was right and helpful 100% (n = 13) 85% (n = 11) 70% (n = 7) 92% (n = 12)
	Mentioned as a source of advice/help	mentioned as a source of advice/help	1986 study (n = 40) HV advised/helped about: mentioned by clients feeding n =13 33% sleeping n =12 30% colic/wind n = 6 15% bowels n = 3 8% medical/developmental problems n = 1 3% cough/cold n = 4 10% teething n = 2 5%	1988 study (n =15) HV advised/helped about: mentioned by clients feeding n = 4 27% sleeping n = 3 20% colic/wind n = 1 7% bowels n = 2 13% medical/developmental problems n = 2 13% cough/cold n = 2 13% teething n = 2 13%

Study	Questions commenting on content of home visit	Responses from clients		
Watson and Sim, 1989 (n = 100)	Subjects recorded as discussed by HV and client	Subject	Mentioned by HV	Mentioned by mother
		Child health issues	85	89
		Mother's health	40	25
		General support	20	15
		Liaison	29	21
		Other	7	6
Quine and Povey, 1993 (n = 777)	Subjects discussed with the HV	Subjects discussed:		Percentage* of women reporting topics discussed:
		Baby's health		77%
		Crying/feeding problems		65%
		Baby's development		59%
		Own health		40%
		The baby's birth		39%
		General feelings		38%
		Other children		20%
		Pregnancy		13%
		Family planning		12%
		Housing		10%
		Relationships		8%
		Partner's health		7%
		Welfare benefits		6%
		Education problems		5%
		Sexual problems		4%
		Family health		3%

* = Percentages are *approximate*, figures taken from bar chart

Study	Questions commenting on content of home visit	Responses from clients	
Cameron, 1994 (n = 45)	Most important areas discussed during the visit according to clients	Topic:	Number of times mentioned:
		Diet	26
		Immunisation	13
		Development	8
		Sleep	2
		Safety	0
		Mother's health	8
		Baby's health	14
		Total	71
Cowpe et al., 1994 (n = 303)	Does your HV give you useful information ?	97.3% (n = 295) responded to question 78.9% (n = 233) said they always or usually got useful information 17.2% (n = 51) felt they sometimes got useful information 3.7% (n = 11) felt they rarely got useful information	

Although, the areas of help and advice the HV is used for are referred to in some studies (Bax et al., 1980; Weatherley, 1988; Cowpe et al., 1994) so little detail is provided that there is little illumination of the client's perspective. This is partly due to question construction and/or method of reporting the findings.

Bax et al. (1980) report three areas (see Table 2.4.1) which clients most frequently selected as having been helped by the HV. No details are given regarding specific issues, or nature and frequency of such help. A number of qualitative comments are provided, but refer to client perceptions of different aspects of the health visiting service. One question in Weatherly (1988) asked 'Does your health visitor give you useful information'? The clients were asked to respond on a 5 point Likert scale: always, nearly always, sometimes, rarely, never. Weatherley (1988, p 138) does not report the response to this question apart from referring to it obliquely: 'The responses to questions 1 to 8 were generally encouraging'. This question was repeated by other HVs (Cowpe et al., 1994) also seeking clients' perspectives on their work. Over three quarters of clients in this study reported that they always or usually got useful information. However, the lack of supplementary questions means that nothing is learnt about *what* it is that clients found useful, and equally, nothing is identified about why information was only sometimes or rarely useful. Further there is no notion of the importance of this information to the client. Information that is rated as useful *may* also refer to something that is considered trivial by the consumer.

The types of problems and areas for help and advice are more fully reported in other studies (Orr, 1980; McIntosh, 1986; Moss et al., 1986; Watson and Sim, 1986; Colliety, 1989; Quine and Povey, 1993; Cameron, 1994). Generally, most of the descriptions suggest that mothers discussed issues concerning their child. However, it may be that in some cases the question construction encouraged this finding.

Orr (1980) investigated 68 clients' perceptions of health visiting. Mothers were asked the purpose of any recent contact with the HV. Orr reports that less than half the mothers had *contacted* the HV. Those that had were predominately concerned (see Table 2.4.1) with a narrow range of child health issues. However, these findings may simply reflect contact

that was initiated by the client and therefore have excluded home visits that were initiated by the *health visitor* which may have included different issues in the discussion.

The author observes later on in the text (Orr, 1981, p 71):

> '*... 45 mothers considered they could not do without their health visitor, mainly because of the desirability of developmental screening and because of their own inability to cope*: [my emphasis]
> *''When it's your first you need a person to listen to, not a whole lot of neighbours telling you different things''*
> *''My mother ran off to England with a soldier and I had nobody to turn to. M/s ... was very helpful, I don't know where I'd be without her - the only thing is she should have more pull with housing''.'*

This statement with the supporting quotes suggests the description of the 'recent' contact between the client and the HV may not reflect the extent of issues discussed with HV.

A later study (Colliety, 1989) asked clients whether they had had any problems *with their child* and noted the sources of help reported for each type of problem (see Table 2.4.1). One aim of the study was to examine the effect of introduction of the health visiting process on clients and HV perceptions of health visiting. Forty clients were interviewed for the first part of the study in 1986 and 15 different clients were interviewed in 1988. The question necessarily limited the mother to responding about the *child.* The clients were also asked about the helpfulness of advice from the HV but this was apparently a general question and not linked with the previous issues about which the mother described seeking advice. The general nature of the question also means that we cannot know about the *frequency* with which help or advice was found 'right and helpful' and whether it applied to all issues or only some.

A similar problem occurs in Moss et al. (1986). The actual question is not detailed, but the authors write (Moss et al., 1986, p 72): 'We asked about problems mothers had had in coping with their babies' [my emphasis].

All responses reported were concerned with child health. However, the wording of the question might have encouraged mothers to restrict their reporting to child health issues. Moreover, these findings refer to reactive work with clients where problems arose, and do not show the work of the HV in working with parents to *avoid* problems or work where the child was *not* the focus or work not restricted to child management problems in the first year.

Four studies (McIntosh, 1986; Watson and Sim, 1989; Quine and Povey, 1993; Cameron, 1994) report clients including issues *not* solely concerned with child health. The largest of these studies (Quine and Povey, 1993) benefits from a random sample, unlike most other studies which rely on small convenience samples. A postal questionnaire included questions regarding home visits made by HVs. Although child health issues were the subjects most frequently reported (see Table 2.4.1) to have been discussed by the mothers, approximately two fifths of clients *also* recorded issues to do with themselves: their own health, the baby's birth and general feelings. The study provides a *general* comment on *all* visits made by the HV. Thirty-four per cent of women had not been visited at home for a year, 52% had been visited up to five times in the last year, 10% between five and 10 times.

In McIntosh's (1986) prospective study, 60 primiparous Glaswegian working class women were interviewed on six occasions. Only 24 of the sample reported receiving advice or help from the HV over the course of the study. Each of these clients reported on average two issues with which the HV had helped. Over a third of the responses were *not* concerned with child health issues. However, as McIntosh points out this figure did not distinguish between advice and help at the clinic or during home visits. Earlier (1986, p 12) he had noted that the majority (61%) of the contacts between client and HV in the study took place in the clinic and not on home visits.

By contrast Watson and Sim (1989) *only* investigated home visits, so this problem with reporting did not occur. The main aim of the study was to examine the congruence between client and HV views about the purpose of the home visit. One hundred clients were visited by a researcher approximately a week after a visit from their HV. Nearly two fifths (n = 38) of the sample were Bengali women. The remaining women were indigenous

or English speaking immigrants. Both HVs and clients were asked about the subjects discussed (see Table 2.4.1).

Comparison of reports for child health issues, general support, liaison and 'other' shows some correspondence between the reports of clients and HVs. This is less marked with the topic 'mother's health'. The researchers commented that clients were much less likely to say that the HV had come to see them as opposed to their child. It may be that if the report of subjects discussed by the HVs was correct that these subjects were not recounted by the mothers because they had less salience for them. The topic 'general support' is mentioned as being received by 15 mothers. Further details of the category of 'support' were provided by the authors and are shown in Figure 2.4.1.

Figure 2.4.1: Description of support (Watson and Sim, 1989, n = 100)

Description of support:
- General support for new mothers, and single parents
- Discussion of marital problems and recent separation
- Support for carer of a patient with a stroke

(Adapted from Watson and Sim, 1989, p 215)

The broad nature of the description indicates complex issues but leaves unclear the nature of the support offered by the HVs and acknowledged as received by some women in the study.

Three studies (Field et al., 1982; Foxman et al., 1982; Clark, 1984) are *not* reported in Table 2.4.1 because the questions asked by the researcher refer primarily to satisfaction with the HV's visits rather than reporting the content of the visits. However, the nature of client responses have some bearing on the *content* of the visits. The three studies refer broadly to positive attributes to do with the HV's personality, someone who will listen to problems and who can give advice. The description 'listening to problems' is mentioned in two studies (Field et al., 1982; Clark, 1984), which might suggest that for some mothers the helpful element was being *listened to* rather than *advice being sought.*

Two potential problems were noted with a number of studies reviewed: the failure to separate clinic visits from home visits and interviewing clients about multiple visits. A summary of studies with regard to these two issues is shown in Table 2.4.2.

Table 2.4.2: Studies differentiating between clinic and home visits and describing number of home visits received by the client

Study (n =14)	Study differentiates between clinic and home visit	Description of number of home visits received by the client
Bax et al., 1980 (n = not stated)	yes	not stated
Orr, 1980 (n = 68)	not stated	interviewed regarding previous contact with the HV (for one question)
Field et al., 1982 (n = 78)	no	not stated
Foxman et al., 1982 (n = 96)	not stated	number of visits up to 7 weeks, average of 2.7 (range 1 - 5 or more)
Clark, 1984 (n = 26)	not stated	range of visits 4 – 28
McIntosh, 1986 (n = 60)	no	range of visits 1- over 10
Moss et al.,1986 (n = 96)	no	number of visits between 7 weeks and interview at 6 months average 1.1 (range 1-5 or more)
Watson, 1986 (n = 101)	yes	mean of 2 visits for 1 group of mothers mean of 3 visits for 2 groups of mothers
Weatherley, 1988 (n = 50)	no	not stated
Colliety, 1989 (n = 40, n = 15, [2 groups])	no	not stated
Watson and Sim, 1989 (n = 100)	yes	interviewed regarding previous visit from the HV
Quine and Povey, 1993 (n = 777)	yes	34% of sample had not been visited at home in last year 52% had been visited up to five times in last year 10% had been visited 5-10 times in last year 4% had been visited more than 10 times in last year
Cameron, 1994 (n = 45)	yes	interviewed regarding previous visit from the HV (for some questions)
Cowpe et al., 1994 (n = 68)	no	not stated

Six of the studies do not ask clients specifically about home visits rather than clinic visits. The nature of health visiting work in clinics and during home visits is different (Clark, 1985) and reports about one area of work do not necessarily reflect on the other. This weakens the conclusions that can be drawn from such studies regarding the work HV's during *home visits* rather than the clinic.

Only three studies asked details about just one visit. Two fifths (n = 6) of studies clearly involved more than one visit. Where researchers did not state the number of visits made by the HV (n = 5), information about the parity of mothers and the ages of children was available. From these details a reasonable presumption could be made that many of these studies included clients who had had *several* home visits. Asking clients in *general* about home visits may increase problems with recall of events.

Summary

General statements from mothers about positive aspects of health visiting have included descriptions of the HV as someone who can listen and help with problems (Field et al., 1982; Clark, 1984). Child health/management issues are the most frequently reported topics discussed (e.g. Orr, 1980; McIntosh, 1986; Moss et al., 1986; Watson and Sim, 1986; Colliety, 1989; Quine and Povey, 1993; Cameron, 1994).

It was observed that some research questions (Moss et al., 1986; Colliety, 1989) appeared to *focus* on eliciting descriptions from mothers regarding child health/management issues and might tend to increase this frequency. Several authors report discussions of maternal and social concerns (McIntosh, 1986; Watson and Sim, 1989; Quine and Povey, 1993; Cameron, 1994). One study (Quine and Povey, 1993) included a substantial minority of mothers who reported issues about themselves.

Reporting in some studies is marred by authors failing to distinguish whether mothers were talking about clinics or home visits and by asking clients about multiple visits. The studies discussed in this section provide some correspondence with the content as described by HVs' reports in Section 2.3. Having established that clients report advice as a key aspect of the work of the HV during home visits, the next section will examine clients' perceptions of aspects of home visits including satisfaction ratings.

Section 2.5 Clients' perceptions of aspects of home visits

This section will examine studies which report clients' perspectives of home visits from the HV. A description of the *content* of visits was discussed in Section 2.4. Additional perspectives regarding home visits include: perceptions of the role of the HV, personal/professional characteristics supposedly linked to satisfaction with home visits and reports of satisfaction with the service.

2.5.1 Clients' perception of the role of the health visitor

The client's understanding of the role of the HV has been explored in some studies. Graham (1979) argues that *use* of the health visiting service will in part rely on the function that clients feel that it serves. Most studies suggest that clients regard the HV's role as primarily concerned with caring for the child (Orr, 1980; McIntosh, 1986; Colliety, 1989; Kendall, 1991; Cameron, 1994; Knott and Latter, 1999). The child protection element of health visiting is mentioned in several studies (Orr, 1980; Clark, 1984; Machen, 1993; Cameron, 1994) although not as a major focus of health visiting. The exception to this is McIntosh's (1986) study, which reports 44% (n = 26) of clients viewed monitoring for abuse or neglect as a *main* function of the HV. Further, 56% of the sample (n = 33) reported the role of the HV *only* in terms of social control.

The HV's role in *supporting* the mother and parents is less clear. Some findings indicate mothers do not perceive health visiting services as a source of support (Moss et. al., 1973; Field et al., 1982; Foxman et al., 1982; McIntosh, 1986; Knott and Latter, 1999). However, Machen (1993) argues that clients in her study (n = 21) had a better understanding of the HV's role because the most frequently mentioned function was the health visitor's help and advice to 'the *mother'* [original emphasis].

An carlier longitudinal study which examined mothers' perceptions of need also identified the HV as a source of support. Primiparous clients (n =21) in Pearson's (1988) study, described three types of helping relationship they had experienced, from lay social networks *as well* as from HVs. These were: advice, support and 'comparing notes'. The respondents were interviewed antenatally, at eight weeks and seven months post partum. The type of relationship needed by the mothers varied over this time.

While few details of the concept of support are provided, the author observes (Pearson, 1988, p 335):

> *' An adviser may offer support, but support is not essential to advice or vice versa. '*

Pearson goes on (1988, p 335):

> *'Support involves the corroboration of information, the provision of reassurance and understanding. Its emphasis is on the 'self' who is being supported in controlling her/his own actions. 'Good' support exists when the respondent feels in control.'*

Moreover, Pearson (1988) suggests that support depends on an informal relationship between the client and the person offering support. In addition, the mother must also perceive a *need* for support. Pearson (1988) argues that if support is offered outside a perceived need this may be construed as judgmental by mothers. At both post natal interviews the author reports that support was important to clients in addition to advice.

Another study found opinion was divided amongst mothers (n = 45) about whether the HV was a source of help for the mother *as well* as the baby (Cameron, 1994). Moreover, while most clients reported being able to discuss their own health, only a minority felt they could discuss issues of a personal nature which were *not* concerned with the mothering role.

Four further studies (Clark, 1984; Pearson, 1984; Colliety, 1989; Kendall, 1991) report a minority of clients referring to the HV offering support although what this concept refers to is not defined. Two of the authors (Clark, 1984; Colliety, 1989) include references by parents to the HV checking they are coping. The latter's report does not make clear whether clients are referring to the HV monitoring parental standards of care, offering a supportive intervention or both. Kendall (1991) notes clients may perceive coping as associated with not being able to manage as a mother, while support may be viewed less threateningly as encouragement.

2.5.2 Personal/professional characteristics linked to satisfaction with home visits

Personal and professional characteristics have been linked by clients with increased or decreased satisfaction with the HV. Some studies examining these aspects of service offer a very limited description. Two studies asked clients whether they had found the HV approachable and provided four fixed responses (Weatherley, 1988; Cowpe et al., 1994). The first author did not report the response. Cowpe et al. (1994) recorded 98% (n = 297) of clients saying the HV was very or fairly easy to approach. No explanation was offered in either study of what approachability might include or the rationale for examining this notion.

Two researchers (Orr, 1980; Clark, 1984) asked clients the characteristics of an *ideal* HV. The most frequently mentioned aspects in both studies were personal attributes such as friendliness, motherliness, being easy to talk to and being supportive. Three other features were also described: knowledge; availability, and the HV being a mother. McIntosh (1986) also notes the value placed by the client on the interpersonal approach taken by the HV. Many mothers described an ideal HV as a 'friend'. McIntosh argues that this term not only suggests an informal relationship but also that the relationship is equal, and non-directive.

The importance of these characteristics is noted in other studies which describe client's reports of *actual* experience of HVs, although they are very briefly reported (Field et al., 1982; Foxman et al., 1982; Watson, 1986; Cameron, 1994). Similarly, a study which examined mothers' (n = 33) attitudes to the work of HVs reports mothers resenting a top down approach by the HVs and being told what to do (Foster and Mayall, 1990). Clients disliked HVs who undermined their own knowledge and felt inhibited in raising issues with the HV if they did not like her interpersonal style. Conversely, they welcomed HVs who used a dialogue/partnership approach.

Two studies which report clients' perceptions of the relationship between themselves and the HV repeat some of the themes that have been described. Cameron (1994, p 173) reports that when clients regarded their relationship with the HV as good she was described as a: 'friend, a sister, a mother, or a helpful neighbour'. By contrast when the relationship

was not as good the HV was discussed in practical, professional terms linking her solely with child health issues.

In contrast to the previous qualitative approaches, Quine and Povey (1993) measured clients' perception of the relationship between themselves and the HV. Twelve items were rated by mothers (n = 777) on a five point scale from '0' - definitely no, to '4' - definitely yes. Most of the mothers (70 - 80%) scored positively most items. Ease of communication, direct answers to questions and appropriate listening were the most highly rated items. Interest shown by the HV and the client's perception of whether the HV was critical or sympathetic towards her were rated least favourably. The authors also reported that women who rated each item more positively had higher satisfaction scores.

2.5.3 Clients' reports of general satisfaction levels

It has been argued that satisfaction levels are a means of evaluating a service and the personnel involved in that service (Merkouris et al., 1999). In addition to consumer comment on features of the service received from HVs, several studies also investigate client satisfaction (see Table 2.5.1).

Table 2.5.1 Client's reported satisfaction with home visits

Study	Questions commenting on satisfaction with home visits	Response from clients
Graham, 1979 (n = 120)	found the visits helpful	at 1 mth - 70% felt visits helpful at 5 mths - 56% felt visit helpful
Bax et al., 1980 (n = not stated)	felt HV had helped	70% of sample
Orr, 1980 (n = 68)	'could not do without their HV'	n = 45 (66%)
Field et al., 1982 (n = 78)	'had mainly positive feelings towards the HV'	n = 47 (60%)
Foxman et al., 1982 (n = 96)	general attitude to service included a question about 'had HV been helpful in any way'	positive with and without qualification 49% mildly positive with and without qualification 24%
Clark, 1984 (n = 26)	found the HV helpful	(n = 18 - responded to question)
	ways in which HV was helpful:	she's a very nice person became a friend n = 9 she listens to your problems n = 5 she gives practical advice n = 5 It was nice to know she was there even if you didn't really need her n = 4 someone to say yes, you are doing it right n = 4 someone you could ring before ringing the doctor n = 1
		total number of responses n = 28 total number of mothers n = 18

Study	Questions commenting on satisfaction with home visits	Response from clients
McIntosh, 1986 (n =60)	do you think her visits were worthwhile? (asked at final interview)	<u>perceived value of home visits</u> worthwhile (*n* =14) 23% not worthwhile (n = 44) 73% don't know (n = 2) 3%
Moss et al., 1986 (n = 96)	general attitude to service included the question: 'had HV been helpful in any way'	positive with or without qualification - 45% mildly positive with or without qualification - 8%
Watson, 1986 (n = 101)	rating of care by HV (2/12 interview)	<u>HV care rated - excellent/very good</u> Bengalis 88% English speaking immigrants 70% Indigenous 61%
	were visits helpful? (8/12 and 14/12 interview)	<u>visits had been helpful</u> (8/12 interview) (14/12 interview) Bengalis 95% 73% English speaking immigrants 92% 67% Indigenous 54% 50%
Weatherley, 1988 (n = 50)	'how helpful have you found the health visiting service as a whole?'	not reported

Study	Questions commenting on satisfaction with home visits	Response from clients
Colliety, 1989 (n = 40, n = 15, [2 groups])	satisfied with service	(1986) child aged 3/12 (n = 15): very satisfied 7% (n = 1) satisfied 93% (n =14) dissatisfied 0% (n =0) child aged 9/12, (n = 13): very satisfied 31% (n = 4) satisfied 69% (n =9) dissatisfied 0% (n =0) child aged 15/12(n = 12): very satisfied 25% (n = 3) satisfied 58% (n =7) dissatisfied 17% (n = 2) (1988) child aged 3/12 (n = 15): very satisfied 13% (n = 2) satisfied 80% (n = 12) dissatisfied 7% (n = 1)
Watson and Sim, 1989 (n = 100)	satisfaction with the visit	satisfied 90% dissatisfied 10%
Machen, 1993 (n = 21)	'on the whole have you found the service useful'?	n = 19, (95%) found the service either helpful or very helpful
Quine and Povey, 1993 (n = 777)	helpfulness of the visits	helpful or very helpful n = 598 (77%) neutral n = 93 (12%) unhelpful or very unhelpful n = 86 (11%)

Study	Questions commenting *on* satisfaction with home visits	Response from clients
Cameron, 1994 (n = 45)	'I did not find this visit useful at all' agree strongly----------disagree strongly (100) (0)	41/45 (91.1%) clients scored between 0-21
Cowpe et al., 1994 (n = 303)	how helpful clients found their HV	255/303 clients felt the HV was helpful (reported as 98.1%)
Jestice and Watkins, 1995 (n = 440)	had their [*clients*]experience of the HV been useful to them?	83.9% (n = 369) said experience had been useful

Most of the studies appear to operationalise satisfaction in terms of helpfulness; three studies ask about usefulness; one study included the term care and one researcher asks respondents 'do you feel you could do without your HV' while another asks clients whether the visits had been worthwhile. The remaining two studies use the word 'satisfaction'. Generally, researchers report 60% or more mothers rate the service from the HV positively. However, particular social and demographic characteristics such as: mother's age, breastfeeding status, parity, child's age, class and ethnicity are associated with variations in these satisfaction rates expressed clients. In addition, methodological issues hinder the clarity of some studies. These points will be discussed in turn.

A significant relationship between positive satisfaction levels and the age of the mother at seven weeks post partum is reported by Foxman et al. (1982). This significant relationship was maintained at six months after birth (Moss et al., 1986). The oldest group of women (30 years and over) reported the most positive attitudes and the youngest (25 years or younger) the most negative. The authors observe that oldest mothers *also* received more home visits and conclude it is not surprising that there was a significant relationship between the two (Moss et al., 1986). While this may be true, it is not *necessarily* the case that extra visits will automatically increase the likelihood of more satisfaction. Quine and Povey (1993) also report that younger women in their study were less likely to be satisfied with the HV.

An association is reported between breastfeeding and increased satisfaction with the HV. Foxman et al. (1982) found that at seven weeks breastfeeding women were statistically more likely to be positive about HVs. An earlier study (Graham, 1979) also reported an association between positive reports of satisfaction with the HV and being a breastfeeding mother.

Several studies only include primiparous clients within the sample (Field et al., 1982; Foxman et al., 1982; McIntosh, 1986; Moss et al., 1986; Machen, 1993; Cameron, 1994). Only two studies which included multiparous mothers examined reports of satisfaction according to mother's parity (Graham, 1979; Quine and Povey, 1993). Graham (1979) reports first time mothers were more likely than multiparous women to rate the HV as helpful during the first five months after the baby's birth. However, the author does not

give any further details so it is not clear what *degree* of difference was found. By contrast Quine and Povey (1993) report *no* relationship between the number of children in a family and satisfaction with the HV.

Few studies have examined the relationship between ethnicity and satisfaction with home visits made by HVs. Two studies report higher satisfaction associated with non-English speaking immigrants, in contrast to the lower satisfaction rates reported by indigenous mothers (Watson, 1986; Watson and Sim, 1989).

Four studies (Graham, 1979; Moss et al. 1986; Watson, 1986; Colliety, 1989) describe a decrease in satisfaction with the HV as the child's age increases. McIntosh (1986) suggested that mothers found the HVs more useful in 'the early stages of motherhood'. This is supported by other studies which report a high level of satisfaction with the HV when interviewed at four or seven weeks (Graham, 1979; Foxman et al., 1982). However, studies which have included mothers with children *over* one old have reported high rates of satisfaction (Bax et. al., 1980; Clark, 1984; Watson, 1986; Weatherley, 1988; Colliety, 1989; Quine and Povey, 1993; Cowpe et al., 1994; Jestice and Watkins, 1995). This suggests that increasing age of the child is not *always* linked with an increased dissatisfaction with HVs.

Conflicting evidence is also apparent in terms of the relative importance or unimportance of the class position of the mother and her reported level of satisfaction. Graham's (1979) study is widely cited as a description of a relationship between the mother's class and satisfaction with the HV (e.g. Field et al., 1982; Clark, 1984; Moss et al., 1986; Machen, 1993). Later findings (Moss et al., 1986) do lend some support to Graham's findings. Moss et al. (1986), report similar satisfaction levels between working class and middle class clients within their sample when interviewed at seven weeks. At six months, although the *overall* satisfaction was approximately the same as previously, there were marked changes between working class and middle class respondents. The middle classes reported increased positive satisfaction rates while working class mothers' positive ratings fell by half while their 'mixed/negative' ratings nearly trebled.

McIntosh (1982) suggests that the influence of class both in his own research and that of others is ambiguous. He points out that two other studies (Orr, 1980; Blaxter and Patterson, 1982) of working class respondents reported much *higher* rates of satisfaction with the HV than his own study. Quine and Povey (1993) also report that generally, in their study, clients with lower socio-economic status were *more* satisfied with the home visits by HVs. It would seem whilst perceptions of the HV and her utility *may* vary between classes this is not always reflected in mothers' reports of the service. The equivocal nature of the relevance or otherwise of client characteristics is a feature of many reports of client satisfaction with the HV.

In addition to the effect of variables on satisfaction levels comment is required about two methodological problems that appear in some studies. First, the problem arising from lack of precision in measurement of satisfaction. Two studies report satisfaction levels but the general nature of the question limits the information it gives on any *particular* aspect of the service (Watson and Sim, 1986; Colliety, 1989). A different problem with question construction occurs in Foxman et al. (1982) and Moss et al. (1986) which report different stages of the same study. Foxman et al. (1982), asked 96 clients the following questions at an interview approximately seven weeks after the birth of their first child (see Figure 2.5.1).

Figure 2.5.1: Questions asked by researchers Foxman et al. 1982 (n = 96)

Each mother was asked:
1. how she felt about the HV and her contacts with her
2. whether the HV had been helpful in any way
3. if there was anything the mother disliked or felt could have been improved
4. if the HV had always done as much to help as she could have done
5. if there were any occasions when the HV's help had been sought and the result had been unsatisfactory
6. whether their had been any difficulty or delay in getting to see the HV
7. whether they were satisfied with the amount of contact they had with her

The client's responses to the seven questions were subsumed into a 'general attitude to service' for each mother. This system of analysis provides the reader with a global reaction but the findings lose specificity. This becomes particularly important if clients perceive *different* aspects of the service *differently*. A clients strongly positive feelings about some aspects of the service may obscure her dissatisfaction with others. This problem is seen again in the subsequent paper describing the study (Moss et al., 1986).

The majority of researchers interview mothers about multiple past visits from the HV (Graham, 1979; Orr, 1980; Bax et al., 1980; Foxman et al., 1982; McIntosh, 1986; Moss et. al., 1986; Watson, 1986; Weatherley, 1988; Colliety, 1989; Machen, 1993; Quine and Povey; 1993; Cowpe et al., 1994; Jestice and Watkins, 1995). Only two researchers (Watson, 1989; Cameron, 1994) have examined clients' perspectives of a *specific* visit. Both researchers investigated the last visit made by the HV and the longest period of time elapsing between the visits of the HV and that of the interviewer was one week. This may lead to improved recall and permit a stronger association to be made between the work of the HV and a specific outcome or lack of outcome.

The other main methodological problem is that only three of the studies in Table 2.5.1 (Watson, 1986; Quine and Povey, 1993; Cameron, 1994) specifically link questions about satisfaction with the service with *home* visits. It is argued (Clark, 1985) that there are four main differences between clinic visits and home visits: time, style of interaction, structure of interaction and content. It is, therefore, of some concern that exploration of satisfaction levels with HV's home visits should actually reflect such visits.

Summary

The majority of studies report that mothers perceive the main function of the HV as concerned with the child (e.g. Colliety, 1989; Kendall, 1991). There is some evidence that mothers also view her as a source of help and advice for themselves (e.g. Machen, 1993; Cameron, 1994). Support is mentioned by clients in a several studies (Clark, 1984; Pearson, 1988; Colliety, 1989; Kendall, 1991; Machen, 1993; Cameron, 1994) but there is little description of the meaning or the value of this concept to the client. Interpersonal characteristics of the HV in terms of friendliness and a non-authoritarian attitude are noted as important by many clients (e.g. McIntosh, 1986; Quine and Povey, 1993).

Most researchers who have investigated satisfaction with home visits have done so in terms of helpfulness (e.g. Graham, 1979; Weatherley, 1988). Some studies (e.g. Watson and Sim, 1986; Quine and Povey, 1993) examine whether satisfaction is related to client characteristics such as mother's age, child's age, class, parity, breastfeeding status and ethnicity, with mixed results. Findings of many studies (e.g. Field et al., 1982;

Weatherley, 1988) are restricted due to authors' failing to distinguish between home visits and clinic visits and examining perceptions of multiple visits.

Section 2.6 Client reports of outcomes of home visits

Part of the value of clients' reports of satisfaction levels is the information they provide about the client's experience of the service. This experience can be seen as of prime importance in attempts to improve the efficiency and acceptability of a service (Quine and Povey, 1993). General questions regarding satisfaction or helpfulness do not identify *what* was helpful or *why* it was helpful, which limits our understanding of the service. It is timely to examine the extent to which studies of consumer perspectives comment *directly* on the outcome of visits from the HV.

This section will report and discuss the information available from consumer reports of satisfaction that reflect on such outcomes. Two main areas of description occur: reports about advice given on the visit, and descriptions of emotional support.

2.6.1 Studies linking satisfaction with advice given by the health visitor

In addition to asking clients about their satisfaction with health visiting, some researchers ask participants to describe in *how* the HV's visits helped. Unfortunately, the reporting of responses is so limited that it does not increase our understanding of the service (Bax et al., 1980; Watson, 1986; Watson and Sim, 1989; Machen, 1993). Bax et al. (1980) give three 'common' areas with which clients report HVs helping. feeding, arranging day care provision and housing. These broad descriptions reveal nothing about the relative importance of these issues, whether it was the quality of advice or another feature of the service that helped. Further, no comment is made about the 30% of respondents who did *not* report the HV to be helpful. Other researchers (Watson and Sim, 1989) limited their exploration about helpfulness *only* to those mothers who did not feel the visit had been helpful, but the responses were not reported.

A reporting problem is also seen in Machen's (1993) study. The author asks clients about the helpfulness of home visits, whether advice received from the HV had been helpful and whether the service was helpful. However, only responses to the last question (which reflect attitudes to the *health visiting service* and not just home visits) are reported.

An earlier longitudinal study examined client perceptions (n = 101) of home visits (Watson, 1986). At the first interview, mothers were asked what advice the HV had given them. Apart from contraception and housing, all issues were concerned with children. Respondents were then asked to rate the *care* given by the HV. The author does not explain whether the rating of care refers solely to the advice described or encompasses more than this and if so what these other elements of HV care might be.

The reporting of the subsequent two interviews is very vague. Helpfulness ratings by the three groups of mothers are followed by minimal qualitative descriptions which provide little insight into why mothers have provided their particular ratings. The possible importance of these descriptions is suggested by the author's remark (Watson, 1986, p 76):

> *'what emerges strongly was that it was the social interaction* [my emphasis] *which was valued by the majority of mothers, who had a desire for someone to talk over their problems with them.'*

However, it is not clear whether simply being able to talk to another person is valued, rather than any advice or help that is offered by the HV. The implication is that something of value to the mother occurred between herself and the HV. It is unclear whether these problems are child centred or to do with the mother and in what way the HV helped. The reporting of the final interview at 14 months whilst recording helpfulness *ratings* of the visits only provides comments on the *frequency* of visiting and nothing about the content or outcome of the visits.

By contrast Moss et al. (1986) specifically examined the helpfulness of the HV's interventions with problems that clients experienced between seven weeks and six months, and six months and one year. Comment on the work of the HV on home visits is limited however because the researchers report clinic visits and home visits together. These researchers observe that a relatively low proportion of mothers chose HVs (and other professional sources) as the 'most helpful' in dealing with problems. The authors argue for more research on current practice and its effectiveness and call for improved training for HVs so they can intervene more effectively with child management problems and ensure that parents are receiving the best advice.

However, the researchers may have inadvertently produced a restricted view of health visiting work, particularly with regard to home visits. The authors noted that most problems occurred in the first seven weeks, as did most home visits made by HVs. At the seven week interview (Foxman et al., 1982) the authors explored the help given by the HV, but the answers to the relevant questions were subsumed within a 'general attitude scale' so no clear account was available of the effectiveness or otherwise of any help that was forthcoming from the HV.

It was only at the six month and 12 month interviews that mothers were asked to nominate *one* particular problem from three categories and describe who was the most helpful source of advice. It would have been of interest to have incorporated the question at *seven weeks* to have taken account of a time when mothers described most problems *and* most visits from HVs. Further it was noted earlier (see Section 2.4.1) that if researchers define mother's problems as those about 'coping with their babies' this may exclude reports of help received from HVs concerned with issues that were *not* centred on babies. Moreover, these findings refer to reactive work with clients where problems arose. It does not show the work of the HV in working with parents to *avoid* problems or work where the child was *not* the focus or work which was not restricted to child problems in the first year.

Cameron's (1994) study is unusual in that it examines outcomes from a *specific* home visit by the HV. The author's primary aim was to examine the relationship between mother and HV through their perceptions of a home visit. Most mothers reported the visit as useful, but Cameron (1994) does not explain *what* clients consider useful about the visit. The author observes that 44 of the 45 mothers report learning something new. However, there are some ambiguities in her reporting of these findings. Cameron (1994) writes that all 45 clients were asked whether they had learned anything new and 32 clients initially answered yes. Those who had said no were asked a probe question about whether any advice was given on the visits. Cameron (1994, p 135) writes:

> *'Of the remaining clients who answered the question in the negative, only one could not think of any advice given in the visit. Thus only one client could not recall any advice or did not learn anything new.'*

This leaves it unclear whether the 11 mothers who required a probe question were referring to remembering advice or learning something *new*. The fact that most mothers said they were going to use the advice does not clarify whether it was *new* advice.

Kendall (1991) reports that analysis of 62 discussions between clients and HVs during home visits indicated that advice was 'often' offered by the HV in areas about which the mother either had *some* information or where the mother was *already* taking action. This suggests that it is relevant to establish whether the advice/information that clients say they have received actually constitutes new knowledge. Cameron (1994) notes that 44 respondents had said they were going to use the advice and *if* they did so, this reflected positively on both the appropriateness of the information and the value of the home visits. Use of the advice or information may indicate appropriateness but may be limited in terms of a description of *value*. Mothers might use some advice/information and still regard it as trivial. Additional information of the client's perception of the advice might have clarified this issue.

The need for clarification is suggested by the responses of clients to the question of whether the HV had helped them with their main concerns in the past month. Thirty one clients reported the HV had helped but the numbers who said 'no' or 'don't know' are not given. Extrapolating from the bar chart supplied, 11 mothers appeared to say 'no' and three 'don't know' (Cameron, 1994, p 136). It is not possible to know what the large minority of negative and ambiguous replies implies. It might be that mothers did not seek advice from HVs about issues that were of *most* concern, or it could be that they approached the HV but she was unable to help.

Clients were also asked to describe the most important thing the HV had said or done for the mother (see Table 2.6.1).

Table 2.6.1: Description of the most important thing that the health visitor had said or done for client (Cameron, 1994, n = 45)

Description of most important thing	Number of mothers
something about baby	21
early visits	9
something about myself	8
antenatally	4
not one thing, or don't know	4
Total *	**46**

* Cameron reports one client chose *two* items

Topics about the baby appear to be most frequently chosen but issues concerning the mother may be a feature of the 'early visits' and 'antenatally' categories. The limited description of the most important input makes it impossible to know what these interventions were.

By contrast with the emphasis of previous studies on descriptions of help being associated with child issues, Clark (1984) reports her study findings indicate that helpfulness of the HV lies in her *personal* qualities (Clark, 1984, p 267):

> *'The key factor seems to be the personal qualities of the health visitor, in particular her perceived friendliness and approachability.'*

However, examination of the table on which Clark bases this statement, does not appear to support this. Just under a third (n = 9) of the 28 responses describe personal characteristics - '*she's a very nice person, became a friend*'. The majority of responses (n = 15) appear concerned with describing the helpfulness of the HV in terms of being a resource either to listen, advise, reassure or to check with regarding the seriousness of a problem. The remaining description is ambiguous - '*nice to know she was there even if you did not need her*' (n = 4). This *might* refer to some kind of reassurance but equally might suggest that the HV had not actually been necessary for these mothers. Moreover the term *'she's a very nice person, became a friend'* may not necessarily represent an endorsement of health visiting activity. McIntosh (1986, p 22) notes that a 'considerable number' of mothers

appreciated the HV's visits *socially*:

> *'She's nice and I really enjoy her visits. She sits down and we just gab. She spends a good hour here. Its company for me.'*

Cameron (1994) also observes that after initial visits from the HV clients commented primarily on the social value of the visits. The HV being described as 'nice' and 'friendly' may be a necessary but not sufficient feature of health visiting activity. It could be argued that it is necessary for 'niceness' and friendliness' of the HV to be associated with an intervention other than simply keeping a person company.

2.6.2 Studies linking satisfaction with advice and emotional support given by the health visitor

Other studies suggest that child issues are *not* the only issues with which mothers associate satisfaction with the HV. Jestice and Watkins (1995) selected a random sample of 20% of clients on Cambridge HVs' lists. The sample consisted of mothers (n = 440) with children under five.

Three hundred and sixty nine (83.9%) mothers reported their experience of the HV had been useful to them. The authors divided the mothers' explanations about usefulness into: 'experiences of practical help' and 'experiences of a more emotional nature'. The former category accounts for 39% (n = 133) of the responses and includes: help with immunisations; infant feeding; weaning; child behaviour (i.e. sleep problems and toilet training); speech disorders; post natal depression; bereavement.

Emotional support was the largest reported category (61.9%, n = 211) and included four different aspects (see Table 2.6.2).

Table 2.6.2: Categories of emotional support (Jestice and Watkins, 1995, n = 440)

Description of emotional support	Number of responses
Advice	95 (45%)
Support	50 (23.7%)
Reassurance	45 (21.3%)
Having somebody to talk to	21 (10%)
Total	**211**

No explanation is provided by the authors regarding the rationale for incorporating a response into one of the two overarching categories, which leaves a number of issues unclear.

Advice is apparently defined as in some way different from 'practical help', including for example, weaning or immunisations. A mother in one of the two quotes supplied to illustrate 'advice' (Jestice and Watkins, 1995, para 4.5.b) notes:

> *'Its good to know that the health visitor 'safety net' exists. The advice I've received has been very sensible and has diffused any anxieties I've had, without making me feel overpowered or threatened as a mother.'*

This description might mean that 'advice' category describes responses from mothers receiving advice on more than one occasion and covering more than one topic. The practical help category may just refer to descriptions of single incidents of advice received on one topic, or many incidents of advice received about one topic.

Additionally, by placing advice within 'emotional support' rather than 'practical help' suggests that these mothers also identified an affective element in the advice from the HV. The quote: *'diffused any anxieties I've had, without making me feel overpowered or threatened'* could be interpreted as a mother obtaining advice from the HV which was also associated with an increased sense of well-being in the mother.

The quote illustrating 'having someone to talk to' (Jestice and Watkins, 1995, para 4.5.b) also suggests an affective component in the usefulness of the HV:

> *'Its been nice to talk to someone who understands my problems and can suggest ways to improve things.'*

Conversely, the quotes defining support and reassurance appear more narrowly focused on child health issues (Jestice and Watkins, 1995, para 4.5.b):

Support:

'My health visitor has always been extremely helpful over any problems I have had with the children and she offers continual support by phoning or calling a few days later to see if her advice has worked.'

and

Reassurance:

'It has been useful to have someone to reassure me about things too trivial to raise with the a GP. It is helpful and reassuring to have to have my children's development checked regularly.'

Additionally, the topics 'bereavement' and 'postnatal depression' would indicate affective components but these are allocated to the 'practical help' category. Notwithstanding ambiguity over the category descriptions this study does report HV outcomes *not* limited to advice about children and include some effect on how the *mother* feels as a result of HV activity.

The importance of the effect on the mother is noted in a study by Quine and Povey (1993). The authors investigated women's feelings as a specific outcome of the HV's visit. Seven hundred and seventy seven women were asked to rate whether they felt more able to cope, more in control and more confident than before the visits. The majority of the sample (approximately 60%) selected the response 'about the same' for the three items. However a substantial minority reported improved affective outcomes: greater feelings of control (31%); greater confidence (38%); greater ability to cope (39%).

In addition, the researchers examined the outcome of advice/information in terms of whether clients perceived the HV had been able to answer their questions and concerns. The findings are shown in Table 2.6.3.

Table 2.6.3: Women's perceptions of whether health visitors had answered their questions and concerns (Quine and Povey, 1993, n = 777)

Questions and concerns:	Responses
completely answered	'almost a third' (no precise figure supplied)
mostly answered	48%
partly answered	15%
not answered	6%

The majority of mothers felt the HV had mostly or completely answered their questions and concerns. However just over a fifth (21%) of clients felt that the HV had not answered or partly answered their questions and concerns. This study is useful because it explores what clients perceive about the outcome of HV visits rather than simply recording the content of these visits or asking a general question about satisfaction which cannot reflect on specific areas of the service. The importance of clients perceiving that their questions and concerns have been answered receives support from a later study (Cameron, 1994, p 124). The author notes that clients judged a home visits a success when; '... they had an opportunity to discuss all they had wanted to, or had learned something'.

Quine and Povey (1993) also asked clients about satisfaction with their home visits. However, in addition to an overall rating of the service they asked clients to rate *six dimensions* of the home visit: accessibility; outcome of care; information; communication; interest shown by the HV and friendliness of the HV. The findings are reported in Table 2.6.4.

Table 2.6.4: Ratings of satisfaction (Quine and Povey, 1993, n = 777)

Dimension of satisfaction	Response
friendliness shown by HV	86%
interest shown by HV	77%
communication skills of HV	76%
quality of information/advice	75%
outcome of care	70%
accessibility	68%
overall rating	73%

Table 2.6.4 shows that in this study an *overall* rating of satisfaction did not necessarily reflect perceptions of satisfaction with *specific* dimensions of care.

Jestice and Watkins (1995) do not distinguish between clients' comments about usefulness of the HV at the clinic and during home visits, whilst Quine and Povey (1993) investigate these areas of work separately. However, both studies incorporate a retrospective design which requires comment.

Mothers in Quine and Povey's (1993) study had one child between eight months and eighteen months old. Fifty eight percent of clients had *more* than one child and some of these children were over five years old. Thirty four percent of clients had not been visited at home for one year, while 52% had been visited between one and five times. A minority (10%) had been visited between five and ten times and a few (4%) over 10 times. This indicates a tremendous range, in terms of possible visits and number of children, about which clients are being asked to submit details. A strength of the study was the specificity of the questions, which allowed a more detailed analysis of the perceptions of HV's service. However, to some extent this strength must be seen to be undermined by the inevitability of specific questions referring to *multiple* visits and perhaps to more than one child.

Fewer details are provided by Jestice and Watkins (1995) regarding their sample but 60% of participants' children were between two and four years. Again, it was apparent from the numbers that some women had more than one child. Therefore, responses in this study could include clinic experiences and multiple home visits covering periods of time from months to years.

Notwithstanding these limitations both Jestice and Watkins (1995) and Quine and Povey (1993) provide important contributions to describing the issues clients found useful and exploring how effective clients perceived HVs in answering their questions and concerns. Further, both studies highlight the importance of how the mother *feels* as a result of the HV's visits.

Summary

Linking clients' reports of home visits with outcomes arising from the visit is problematic. First, responses regarding how HVs helped are not always reported (Foxman et al., 1982; Machen, 1993). Alternatively, reporting may be so limited as to provide no understanding

about why or how HVs helped or how significant this help was to mother (Bax et al., 1980, Watson and Sim, 1989). As important is the failure to ask clients about dissatisfaction (Bax et al., 1980, Watson, 1986). In addition, the question construction of one study may have biased mothers to comment *only* on advice/information concerned with children (Foxman et al., 1982, Moss et al., 1986).

While most studies associate helpfulness with advice given by the HV, there is usually no attempt to confirm that advice/information has actually been used (Bax et al., 1980; Foxman et al., 1982; Moss et al., 1986; Watson, 1986; Watson and Sim, 1989; Quine and Povey, 1993; Jestice and Watkins, 1995). Moreover, there is little explanation about how or why mothers find this advice helpful.

Finally, more recent studies suggest that satisfaction with home visits may in part be a consequence of mothers feeling emotionally supported by HVs (Jestice and Watkins, 1995) or feeling more able to cope following a visit (Quine and Povey, 1993). Whether this is a result of advice or other aspects of the interaction is unclear, as is importance to the mother.

Section 2.7 An Overview of the Concept of Support

This literature review has examined reports from HVs and clients about content of home visits. In addition to descriptions of advice and information, several studies (Clark, 1984; Pearson, 1988; Colliety, 1989; Kendall, 1991; Machen, 1993; Cameron, 1994) report descriptions of 'support' being received from the HV. Only Pearson (1988) describes what support might entail. This description also encompasses support received from sources *other* than HV. None of these studies explores clients' perspective regarding any contribution to their well-being of support received from the HVs. This concept of support was noted earlier (Section 2.2.2) in the proposed extension of health visiting activity in supporting parents. This section provides an overview of theoretical explanations of support, in order to explore the value, if any, of this concept in health visiting.

Leavy (1983, p 3) makes the following observation:

> *'What, exactly, is social support? While most of us have a feel for what support involves, a mere feel for a concept does little to provide a theoretical framework for research and intervention.'*

This quotation illustrates that discussion of support in the literature is made in the context of *social* support, which is widely taken to refer to effects arising from interpersonal relationships between people (Wortman, 1984, p 2339). Madge and Marmot (1987) note there appears to be a consensus among lay people and academics that there is something beneficial to health about social relations, although exactly what the relationship *is* is not yet clear (Madge and Marmot, 1987; Milne, 1999; Stansfeld, 2000). Madge and Marmot (1987) report that social support has been studied from a variety of perspectives that have included *different* social relationships (the social support in friendships or in being a member of a religious group) and involved debates about how social support should be interpreted (Broadhead et. al., 1983; Leavy, 1983; Stewart, 1993). In a review of different approaches to investigating support Veiel and Baumann (1992, p 6) observe:

> *'... social support can refer to a person, social structure, role, transaction, attitude, perception or other state of mind.'*

Reviews of different taxonomies of social support identify six different types of support: emotional support which allows the person to feel they are cared for by others; social integration or the sense that an individual is part of a network; bolstering an individual's sense of self-esteem; instrumental aid; offering advice and information and providing information that the individual is part of a network of reciprocal help (Wortman, 1984; Cutrona and Russell, 1990). The importance of these different elements of support lies in the value they may have in enabling people to avoid or cope with stressful physical or psychological events.

2.7.1 Functions of support

Reviews and studies provide evidence of a link between social support and numerous positive mental and physical health outcomes (e.g. Brown and Harris, 1978; Broadhead et

al., 1983; Leavy, 1983; Wortman, 1984; House and Khan, 1985; Madge and Marmot, 1987; Bloom, 1990; Oakley et al., 1996). Four main explanations (Madge and Marmot, 1987; Bloom, 1990) are offered about how social support might affect well-being: by direct effect on health; by reducing the negative impact of stressors on health; by decreasing risk of exposure to hazards, by facilitating recovery from illness. Two major theoretical approaches (the 'buffer effect' and 'the main effect') have been developed to explain how social support might achieve such outcomes.

Cobb (1976) argues that social support modifies the effect of stress on an individual throughout the inevitable transitions and crises of life. Social support, he reasons, helps people manage problems and facilitates adaptation required by individuals. This notion of support as a 'buffer' against the effects of stressors is also supported by Cassel (1974). The presence of others may enable individuals to regard potential stressors (e.g. unemployment) as less threatening because of the perceived sources of help with the problem. In addition, supportive relationships may increase the belief of individuals in their *own* ability to cope.

Both authors advocate teaching people how to give and receive support in order to maximise their ability to cope with stressful life events. Cobb (1976) conceives that the person receiving support would feel one or more of the following: a feeling of being cared for; valued as an individual, a sense that they belonged to a network involving communication and mutual obligation. Caplan (1974) adds elements to this model. Supporters might also offer information and feedback which might help the individual deal with the problem, and also practical help (e.g. money). The buffering effect is operative only in situations of high stress. In situations of low stress little or no buffering occurs (Sarafino, 1990).

By contrast, social support can also be seen as contributing to well-being irrespective of whether stress is present (the main effect) (Gottlieb, 1987, p 51). The author explains:

> *'... social support serves as a primary preventive in part by offering ongoing feedback and anticipatory guidance, and by conditioning a sense of reliable alliance in a peer network characterised by mutual effect.'*

Thus, individuals may have their well-being enhanced by an increased sense of self esteem arising from positive feedback from a social network. A social network may also influence positive health behaviour such as support to give up smoking or encouragement to seek help with problems (Sarafino, 1990; Milne, 1999).

A review of the literature examining the buffer effect and the main effect of social support (Cohen and Wills, 1985) notes different conclusions reached by studies regarding which model has the greater validity. The authors concluded that there was evidence to support both models. Cohen and Wills (1985, p 349) reported that the buffer effect and the main effect represent *different* processes whereby social support can affect an individual's well-being. The latter effect refers to the extent to which an individual is integrated or embedded within a network of social relationships. In a situation of stress these would not necessarily enhance a person's ability to manage the situation. However, social networks lead to a sense of psychological well-being which may enhance the immune system affording protection against ill health. In addition, network members can influence health status by offering information about potential stressors, and encouraging health enhancing behaviour.

With regard to the buffer effect, the authors note that different situations may require different elements of support, but generally, emotional support and informational support are the most common elements. Both these features of support are congruent with a broad range of stressful situations while other elements (i.e. tangible aid in the form of money) may be confined to more specific issues. Further, it is suggested that the buffering effect can *only* operate where there is a match between the need elicited by the stressors and the elements of offered support (Cohen and Wills, 1985; Cutrona and Russell, 1990; Cohen, 1992). In addition, studies reviewed provide evidence that effects of chronic stress *in addition* to episodes of acute crisis can be modified by social support.

2.7.2 Support and coping

Several researchers comment on the connection between the study of social support and the study of coping (e.g.: Gottlieb, 1985; Gottlieb, 1987; Oakley, 1992; Stewart, 1993; Milne, 1999). Lazarus and Folkman (1984, p 141) define coping:

> '*... constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.*'

Cognitive appraisal is the primary response made by an individual when judging whether a stressor should be regarded as: a threat, a harm, or a challenge (Gottlieb, 1987). The second stage of this process requires the individual to assess the personal and environmental resources available to help them cope.

In terms of the primary processes, Gottlieb (1987) argues that a social network can provide information which can help the individual appraise the severity of the stressor. Further, the individual can use the *reactions* of others as a guide to the appropriateness of their *own* reactions. In addition, the availability of social support will be a factor when an individual assesses the resources they can use to manage the stressor.

Although descriptions of social support usually refer to positive effects, there is a recognition that it may involve negative outcomes for individuals (Stewart, 1993). Seeking or receiving support may be perceived negatively and further undermine the individual's feeling that they can cope. Similarly, inappropriate offers of help about an issue where a person perceives themselves as competent may lead to reappraisal that they are in fact incompetent (Wortman, 1984; Stewart, 1993). Moreover, support may encourage maladaptive behaviour that hinders an individual's ability to manage a problem (Sarafino, 1990).

In addition, a number of studies reviewed by Wortman (1984) report the lack of understanding by some people about what a person may find supportive. The author gives the example of one study that reported attempts by individuals to comfort parents whose baby had died. The comments included: 'you can always have another one' and 'it was

only a baby whom you didn't know - it's worse to lose a child you know' (Wortman, 1984, p 2347). Parents reported that such statements actually increased their sense of grief. Moreover, there is evidence (Silver et al., 1990) that the distress exhibited by some individuals faced with a stressor may result in supporters feeling uncomfortable and vulnerable. As a consequence of these negative feelings they may decide to reject the person seeking support with the risk of *increasing* that individual's distress.

2.7. 3 Social and professional support

Stewart (1993) notes that conventional discussion and research about support refers to that given by an individual's *personal* network. The author notes that professional support should be considered as (Stewart, 1993, p 2): 'surrogate support ... extending the support available in the client's network and replacing that which is not available'. Winefield (1987) suggests there are similarities between social support and therapeutic interventions. Both can be described as help and both can benefit the individual in terms of the positive personal interaction. However, Winefield (1987) argues that therapists base interventions on a theoretical framework that lay persons lack. In addition, whereas a supportive relationship between lay persons involves reciprocity of support, in a therapeutic setting support is unidirectional. Similarly, Thoits (1986) notes the importance of the professional's knowledge base for some clients when determining from whom they should seek help.

Reviewing some of the literature concerned with examining support offered by therapists and by lay persons Milne (1999) notes a 'traditional emphasis' on differences between the two groups. However he suggests, that there are also important areas of continuity and possible overlap (Milne, 1999). He argues that principles of social support are intrinsically bound up with any formal therapy because they are both concerned with human interactions. Moreover, Milne (1999) believes that therapeutic interventions would benefit from the inclusion of features which reflected a commitment to social support. Such features would involve: ensuring that services were accessible and treated people with dignity; inclusion of 'manifest aspects' of social support such as warmth, mutual respect and interest not confined to the clinical problem; acknowledging the client's social support system.

The author goes on to suggest that the relevance of social support in therapy has been previously acknowledged by the investigations into the non-specific effects of therapy otherwise known as the placebo effect, he comments (Milne, 1999, p 106):

> '*the so-called non-specific and rather mundane ingredients of therapy (such as social support) may actually play a powerful part in promoting clinical outcomes.*'

The relevance of the placebo effect and social support has also been noted by Oakley (1988; 1992). She explains that the placebo response refers to the phenomenon whereby an individual can feel better or worse from ingestion of a substance, or undergoing a procedure or process which is considered to lack the capacity to produce such an effect. In reviewing several drugs efficacy trials Oakley (1992) notes that placebos have been found to be effective in a range of conditions and *also* responsible for side effects.

Similarly, with psychotherapeutic interventions placebos were found to provide as much benefit as some therapeutic interventions. Oakley reports the following observation made by Frank (Frank, 1983, p 291):

> *'With many patients the placebo may be effective as psychotherapy because the placebo condition contains the necessary, and possibly the sufficient, ingredient for much of the beneficial effect of all forms of psychotherapy. This is a helping person who listens to the patient's complaints and offers a procedure to relieve them.'*

Similarly the *attitude* of doctors towards patients has been noted to effect positive outcomes for patients regardless of the treatment offered. Oakley suggests social support can also be viewed as 'placebo therapy'.

Based on the evidence that social support is beneficial to well-being, Oakley (1992) conducted an RCT examining the effect of social support on pregnancy outcomes of socially disadvantaged women with a history of having had a low birth weight baby. Social support consisted of a minimum package of three home visits and two telephone

calls during pregnancy by a research midwife with a brief postnatal visit. In addition, mothers had 24 hour telephone access to their midwife in the active treatment group. The midwives were asked to give information and advice *only* if asked by mothers. Listening and responding to the concerns of the *mother* rather than following a professional agenda were paramount as Oakley notes (1992, p 132):

> *'The midwives' personal relationships with the women, their ability to develop a rapport and react sensitively to the women's expressed needs and problems, were crucially important.'*

Significant differences between intervention and control groups were found regarding pregnancy, labour, delivery and postnatal health of the mother. Women in the intervention group were also less likely at six weeks post partum to say they were worried about their baby (Oakley et al., 1990). A follow up questionnaire sent to the participating mothers seven years later also demonstrated continuing differences between the social support and control groups (Oakley et al., 1996).

Summary

Support is a possible outcome from social relationships which can include a wide variety of individuals, structures, roles or attitudes (Veiel and Baumann, 1992). Numerous definitions exist but there is broad agreement that the concept is multi-dimensional and involves the perceived caring, esteem and aid that an individual receives from another individual or group (e.g. Sarafino, 1990; Cutrona and Russell, 1990). There is evidence that support may affect the physical and/or psychological well-being of an individual although it remains uncertain precisely how this occurs (e.g. Madge and Marmot, 1987; Oakley, 1992). Seeking or offering support is not *always* appropriate and in these situation may have negative outcomes (e.g. Wortman, 1984; Stewart, 1993). Social support received from laypersons may be different in some respects from that received from professionals (e.g. Winefield, 1987; Stewart, 1993). However, the latter group also appears to be able to affect health outcomes for individuals (e.g. Oakley et al., 1996; Milne, 1999).

Section 2. 8 Chapter discussion

It has been noted that the evidence base for nursing interventions requires development (DoH, 1997; 1999b; 2000b). Particular mention has been made of the invisibility of primary care nursing of which health visiting is a major component (DoH, 1999c). Moreover, recent research (Elkan et al., 2000) has highlighted lack of knowledge concerning British health visiting, in particular the effectiveness of routine home visiting. In addition, there is government interest in increasing support and advice available to families from HVs including home visits (DoH, 1998b). These concerns and interest provide the rationale for the current investigation of clients' reports of home visits.

Some researchers argue that the relationship between HV and client is instrumental in achieving positive client outcomes (Robinson, 1982; Campbell, 1995). However, some studies submitted as evidence of this assertion are weakened by being based on accounts by HVs (Chalmers, 1990; Cowley, 1991; De La Cuesta, 1992). This is highlighted by other studies that record different perceptions of health visiting work by the client and the HV (Pearson, 1988; Kendall, 1991).

Health visitor reports of content of home visits note a wide variety and number of issues discussed (Marris, 1971; Clark, 1973). Most clients are mothers with children under five years old and most issues discussed are child related. The one study that recorded time spent on each topic suggests that child issues were the most important (Watson, 1981). The client's perspective of these visits was not reported.

Quantitative approaches which categorise and code HV activity have been criticised as inadequate (Clark, 1985; Montgomery-Robinson, 1987). It is argued that issues of self reporting by HVs present problems with methodological rigour (Clark, 1985; Montgomery-Robinson, 1987). It was argued above (Section 2.3.4) that while these objections illustrate methodological difficulties that *may* arise, there was no reason in principle why coding and categorisation of health visiting activity should not be adopted.

Clients' perspectives of the content of home visits by HVs appear to show most contact was focused on problems with children (Orr, 1980; McIntosh, 1986; Moss et al., 1986; Watson, 1986; Colliety, 1989; Watson and Sim, 1989; Quine and Povey, 1993; Cameron,

1994). Four studies include client reports of issues *not* solely concerned with child health (McIntosh, 1986; Watson and Sim, 1989; Quine and Povey, 1993; Cameron, 1994). However, it was noted (see section 2.3.1) that the question construction used by some researchers may have biased responses towards issues concerned with children (Orr, 1980; Moss et al., 1986; Colliety, 1989).

In addition, although it is argued (Clark, 1985) that health visiting work in the clinic and during home visits is different, several studies do not distinguish between these (Field et al., 1982; McIntosh, 1986; Moss et al., 1986; Weatherley, 1988; Colliety, 1989; Cowpe et al., 1994; Jestice and Watkins, 1995). Moreover, it was observed that there may be a problem with recall of events in studies that require some clients to comment on multiple visits received from HVs, sometimes up to several years previously and involving more than one child (Foxman et al., 1982; Clark, 1984; Moss et al., 1986; Watson, 1986; Quine and Povey, 1993; Jestice and Watkins, 1995).

Several studies suggest that clients view the HV's role as primarily concerned with the child (Orr, 1980; McIntosh, 1986; Colliety, 1989; Kendall, 1991; Cameron, 1994; Knott and Latter, 1999). Support is described as offered by the HV to the mother in some studies but there is little description of what this concept might involve (Clark, 1984; Pearson, 1984; Pearson, 1988; Colliety, 1989; Kendall 1991; Machen, 1993; Cameron, 1994). Many researchers record the importance to mothers of HVs who have good interpersonal skills (Orr, 1980; Field et al., 1982; Foxman et al., 1982; Clark, 1984; McIntosh, 1986; Watson, 1986; Cameron, 1994).

In terms of satisfaction, researchers generally report 60% or more mothers positively rating the service from the HV (Bax et al., 1980; Field et al., 1982; Clark, 1984; Colliety, 1989; Watson and Sim, 1989; Machen, 1993; Quine and Povey, 1993; Cameron, 1994; Jestice and Watkins, 1995). However, findings about the association between client characteristics and satisfaction with home visits are mixed (Graham, 1979, Bax et al., 1980; Field et al., 1982; Clark, 1984; Moss et al., 1986; McIntosh, 1986; Watson and Sim, 1989; Quine and Povey, 1993; Cowpe et al., 1994; Jestice and Watkins, 1995).

In addition, interpretation of some findings regarding satisfaction is hindered in some cases because of problems with question construction (Foxman et al., 1982; Moss et al., 1986; Colliety, 1989; Watson and Sim, 1989) and the failure of researchers to distinguish between satisfaction with home visits and clinic visits (Graham, 1979; Bax et al., 1980; Orr, 1980; Field et al., 1982; Foxman et al., 1982; Clark, 1984; McIntosh, 1986; Moss et al., 1986; Watson 1986; Quine and Povey, 1993; Cowpe et al., 1994; Jestice and Watkins, 1995).

Clients' satisfaction may be used as a measure of outcome of care. Further, the client's perspective is acknowledged as vital to an understanding of the service from the user point of view and intrinsic to maintenance and improvement of quality of the service (Quine and Povey, 1993). However, studies reporting satisfaction frequently cannot inform us about the *outcome* of the HV visit. In addition, at times the reporting of some studies is so limited that the reader cannot know in *what way* the HV has helped (Bax et al., 1980; Watson, 1986; Watson and Sim, 1989; Machen, 1993).

Advice, particularly regarding children, is the item of service most commonly linked with satisfaction. It is not clear whether the advice is new knowledge *or* is used by mothers (Kendall, 1991). Only one study, whose sample was restricted to primiparous mothers with babies under six months, has asked whether the mother would *use* the advice (Cameron, 1994). A few studies suggest that in addition to issues concerned with children, satisfaction for some mothers is linked with emotional support and the mother feeling better as a consequence of the visit (Quine and Povey, 1993; Jestice and Watkins, 1995).

Several studies recorded a number of clients describing support as a service received from HVs, but provided little or no description about the meaning or relevance of support to clients (Clark, 1984; Pearson, 1988; Colliety, 1989; Kendall, 1991; Machen, 1993; Cameron, 1994). Consequently, it was not possible to know how support impacted on the client's well-being.

Overviews of theoretical approaches relating generally to the notion of social support identifies two main ways in which support might maintain or improve an individual's well-being: the buffer and the main effect (Cohen and Wills, 1985). In addition, the effect of

support on coping strategies was also noted (Lazarus and Folkman, 1984). Although the importance of the social support of an individual's personal network is acknowledged, it was argued that professionals may employ social support as a therapeutic intervention which can produce positive health outcomes for clients (Oakley et al., 1996; Milne, 1999).

In summary, the disparate nature of many previous studies leaves clients' perspectives of home visits unclear. Topics discussed during visits have been identified by HVs and a presumption of the most important topic has been made by researchers based on the amount of time spent on the topic. The *client* has not been asked to identify their perspective regarding the most important issue discussed.

Where clients recorded information discussed, whether this is new or subsequently used was not clear. One study which *has* asked clients whether they received new advice and whether they intended to use it leaves the former issue unclear. In addition, the sample was restricted to primiparous mothers with children generally under six months of age.

Satisfaction ratings rarely assessed the elements of service provided by the HV during a home visit. Rather, clients rated helpfulness or usefulness with no exploration by researchers of what these ratings referred to. In addition, the relevance of advice/information in terms of its importance to the mother has not been established. Finally, the impact of home visiting on the well-being of the mother through support is suggested in some studies. However, this concept has not been explored to elucidate what value, if any, support has for clients.

Therefore, this thesis addresses these issues in an attempt to clarify the outcomes of the work of the HV during home visits.

CHAPTER 3

LITERATURE REVIEW OF THE WORK OF THE HEALTH VISITOR AS A SOURCE OF ADVICE/INFORMATION IN THE CHILD HEALTH CLINIC

Section 3.1 Introduction

This review seeks to establish the current state of knowledge of the HV as a source of advice/information in CHCs.

Child health clinics have always been concerned with trying to improve the health of children and mothers. However, both the nature and the providers of this service have changed since its inception. In the first section, these developments are outlined to provide context for the review. The subsequent three sections discuss studies which have described work of the HV in the CHC. A summary is provided at the end of each section. The final section is the chapter discussion which explores main issues arising from the review and provides the rationale for the current investigation.

3.1.1 Search method

Several sources of literature were consulted during the study and are described below.

Computerised databases

A formal search was undertaken several times during the course of the study. The following databases were examined:

ASSIA	1987 - 2000
Cinahl	1983 - 2000
Dissertation abstracts	1988 - 2000
Medline	1966 - 2000

The search employed the following keywords, which were also used in combined searches:

baby clinic*
child health clinic*

clients' perceptions
child surveillance clinic*
child welfare clinic*
consumers' perceptions
health surveillance clinic*
health visit*
infant welfare clinic*
mothers' perceptions

* = truncation, to find all words based on a root (Smeaton, 2000)

Only papers which referred to British child health clinics were included for review. There is no equivalence between countries in the nursing roles within CHCs therefore, it was not appropriate to consider literature which described foreign community nursing roles. Where the title indicated that a paper was irrelevant to the study, it was discarded. Abstracts from all other papers were examined. Where the abstract was relevant, or when there was insufficient detail to ascertain its value, papers were obtained. The same procedure was used for the examination of references found from the examination of papers.

Although 'child health clinic' may be regarded as the modern term for this service there have been other names such as 'well baby clinic', 'infant welfare clinic' and 'welfare clinic'. To avoid confusion clinics are always described by the researcher as CHCs (child health clinics). Quotes from other studies retain original descriptions.

Section 3.2 The health visitor in the child health clinic

This section provides context for the literature review by outlining the origin and development of the principles underlining the function of CHCs. The focus is on major reviews that have investigated child health services since the 1946 National Health Service (NHS) Act. A description is provided of how screening tests and immunisation programmes have built on the initial advisory work of CHCs. It is argued that previous investigations of CHCs have focused on these aspects of the work especially on the screening elements of the programme. Consequently, the advisory work of the HV which has always existed as a feature of the CHC service has received less attention.

The shift of interest at national level towards primary prevention with concomitant lessening of emphasis on secondary prevention with children, such as screening checks, is noted. It is argued that evidence suggests clients may attend CHC for reasons other than screening checks or immunisations. These points provide a rationale for the current investigation.

3.2.1 Origins of the child health clinic

Child health clinics were established by doctors in France in 1892 from a concern with the high infant mortality rate (McCleary, 1933; Newsholme, 1935). Initial aims of these early CHCs were: weekly weighing, examination of all children under two years old, promoting breastfeeding, provision of modified cow's milk for children not breastfed (McCleary, 1933, p 49). Maternal ignorance regarding child care was viewed as a key factor in infant mortality. Consequently, it was reasoned this regular contact with mothers provided an opportunity to teach women the best way to care for their babies.

In the United States, similar concern with high mortality rates led to the establishment of a milk depot in 1893. This intervention focused on supplying uncontaminated milk to mothers but did not include an element of medical supervision and education.

Similarly, the British CHCs, which opened in 1899, did not incorporate medical consultations. However, HVs visited children receiving milk from the centres and reported their progress to the medical officer of health (McCleary, 1935). The educative aspect of CHC work increased following the establishment of a voluntary centre in London in 1906. The emphasis of the advice was concerned with keeping the child well. Mothers were given individual guidance according to their needs (Loveland, 1968). Health visitors attended the CHCs and carried out home visits to reinforce advice given at the centres.

The initial concern of CHCs was with children under one year of age. This focus was extended to include all children under five and the health of the mother. From 1914, the government gave grants to aid this work, which promoted further extension of the service (Dingwall, 1997). By 1933, there were 3,113 centres which had a variety of clinics including CHCs. Of this number, 2,343 were provided by local authorities and 770 by

voluntary associations (McCleary, 1935). The inception of the NHS changed CHCs from voluntary status to a mandatory requirement of local authority provision.

In less than 50 years, CHCs had become an established service available to those mothers who chose to attend. The initial concern with providing uncontaminated milk and the encouragement of breastfeeding quickly developed to incorporate an educational aspect that provided advice on all issues of caring for children. The service was led by the medical officer who provided examinations, in addition to advice for the mother. The HV was always part of this service, involvement in the advice aspect of the work increasing as the professional base of health visiting became established. By the time the NHS was formed, the basis of the motivation for CHCs had altered. Infant mortality rate had decreased dramatically (McCleary, 1935) the general knowledge of mothers regarding child care had improved and there was a source of free medical care for mothers and their children (Douglas and Blomfield, 1958).

3.2.2 Establishing the importance of screening in child health clinics

Concern arose about whether CHCs were meeting the modern needs of mothers (MoH, 1967). The Sheldon committee was established to examine child welfare clinics. The medical perspective of the committee was demonstrated by its terms of reference which were (MoH, 1967, p 5):

> *'To review the medical functions and medical staffing of the child welfare centres and to make recommendations.'*

The committee reviewed two types of literature: investigations of the adequacy of the service to meet modern needs, examinations of the work carried out in CHCs.

Regarding the former, two of the three studies the committee reported (Spence et al., 1954; Miller et al., 1960) suggested CHCs had been instrumental in reducing childhood mortality and morbidity. However, the authors expressed concern that mothers were not attending CHCs as frequently as was desirable. The CHC was perceived as a valuable source of advice and guidance for mothers. The remaining study also referred to the importance of

the social and educative approaches of the maternal and infant welfare services in reducing childhood mortality (Douglas and Blomfield, 1958).

Four further reports were reviewed which investigated work undertaken by the CHC. The Sheldon committee concluded that these studies showed that the focus of CHC work was: weighing children; giving advice and reassurance to mothers; vaccinations and immunisations programmes, the sale of welfare foods. The importance of these activities varied between studies. Two of the investigations are briefly outlined by Sheldon, but few details are provided of the study method and findings limiting their value. Follow-up of the studies is not possible due to a lack of references. The remaining two papers authors examined the use made by clients of the CHCs and noted how few mothers attended the CHC to see the doctor (Acheson, 1962; McIntosh, 1964).

McIntosh (1964) reported that of 1,054 mothers 9.5% (n = 100) attended for advice from the doctor, and a further 9.1% (n = 96) received an immunisation from the doctor. This is contrasted with 67.6% (n = 714) who had their baby weighed and whom McIntosh reasoned also had advice from the HV. McIntosh (1964, p 222) comments dryly:

> *'Apparently only one of the 1,054 attenders considered a visit to the doctor alone to be sufficient reason for coming.'*

He adds:

> *'My findings place me in agreement with Acheson (1962) when he says that "searching enquiries" should be made on whether expensive facilities concerned with routine medical care of babies and small children are still necessary, and if so what shape they should take.'*

Similarly, Acheson (1962, p 1358) noted:

> *'The most striking and to some extent surprising finding in this study is that, despite the fact that the doctor was always present in these areas, such a very large proportion of the mothers (62%) should come to the clinics to obtain*

some sort of service from the health visitor, and that in their minds weighing should be such a popular procedure.'

Acheson adds that the efficiency of the service rests "squarely on the shoulders of the HV", describing the importance of recognition of her skills and the need for GPs to work with her if they wish to develop preventive child health care in their practices.

Both these papers suggested that mothers' focus for visits to CHCs did not appear to be with screening of their child or immunisations, but with weighing and perhaps advice. Furthermore the CHC worker seen was most likely to be the HV. By contrast, the Sheldon committee in their discussion of the work of the CHC focused on the role of the doctor and the importance of regular examination of the child and detection of defects. The committee proposed that the CHC should have the following functions (see Figure 3.2.1).

Figure 3.2.1: Function of the child health clinic - Sheldon Committee (1967)

- routine medical examination
- advice on infant nutrition
- detection of defects
- parent counselling
- health education
- measurements
- immunisation and vaccination
- food sales

(Adapted MoH, 1967, p 35-36)

Most of these functions were envisaged as being delivered by medical staff with a few exceptions. HVs in addition to doctors are mentioned as being able to provide advice on infant nutrition, carry out six month hearing tests and pre-school vision testing. Recommendation was also made that health education officers should be responsible for development of health education within the CHC. The main thrust of the report is concerned with a discussion and description of the medical functions of the CHC, the correct training of doctors, the desirability of child health services being situated within general practice, relationship with other services and a suggested programme of screening tests (MoH, 1967).

The screening of children through tests for developmental delay, growth monitoring and tests of vision and hearing has subsequently retained a central place both in research activity and in discussion about the function of CHC (DoH, 1989). The programme of screening tests proposed by the Sheldon committee was supported and developed by the Court committee (Committee on Child Health Services, 1976).

3.2.3 Child health surveillance programme

The main concerns of the Court committee with regard to CHCs were: non-attendance by certain groups of mothers, poor uptake of immunisations programmes, division of the curative and preventive aspects of child health, desirability of situating CHCs within general practice. Court gave a general endorsement of the value of CHCs but pointed to the need for substantive evidence to demonstrate the effectiveness of screening tests. Notwithstanding the lack of evidence, Court argued for a series of similar tests to those proposed by Sheldon. Screening activities were an element of a preventive child health programme described by Court as 'child health surveillance' to cover all levels of preventive child health care: primary, secondary and tertiary (see Figure 3.2.2).

Figure 3.2.2: Child health surveillance programme - Court Committee (1976)

- oversight of health and physical growth of children
- monitoring of the developmental progress of children
- providing advice and support, and treatment and referral of the child
- providing an effective infectious disease prophylaxis
- participating in education and training for parenthood

(Adapted from Committee on Child Health Services, 1976, p 132, para 9.6)

These five elements, with modifications, have subsequently been used by many in defining child health surveillance (DoH, 1989, p 6). However, the concern regarding the poor evidence base for the screening checks has remained a cause of much debate. A review of the evidence of effectiveness of different aspects of surveillance programmes as well as a discussion of the struggle between community child health doctors, general practitioners, HVs and community consultant paediatricians for control of child health surveillance is provided by Butler (DoH, 1989, p 20). The author describes the CHC in similar terms to

Court:

> *'Child health clinics operate partly on an open access basis, in which parents are able to bring their children on their own initiative for weighing and measuring, advice on feeding, and so on ... In many areas the clinics also incorporate systematic screening programmes for children at specified ages, reflecting the DHA's policy on pre-school surveillance.'*

The CHC is again described as having a dual function: provision of advice for parental concerns and a screening service based on professionally defined needs for child health care. Both Sheldon and Court incorporated advice and support for parents as an element of their preventive child health programme. However, research has concentrated on efficacy of the programme of health surveillance in terms of the *screening programmes* offered in CHCs, as Butler's review of the twenty years of research since the Sheldon report demonstrates.

However, although screening tests may be an important aspect of health surveillance they are not the only service offered within a CHC or the only aspect of preventive child health programmes. It could be argued that the increase in interest in screening tests since the inception of the NHS has led to a lack of attention to the advisory element on which the service was founded. However, this might not be of consequence if clients attend solely or in the main, for immunisations and screening programmes and view this traditional feature of CHC work as redundant.

3.2.4 Attendance patterns and screening tests

If clients only visit CHCs in order to receive screening tests and immunisations a certain attendance pattern and number of visits would be expected. Children's ages and frequency of attendance at CHCs can be compared with the age at which screening tests and immunisations are offered. This allows comment about the likelihood of clients attending for reasons *other* than a screening test or immunisations.

However, some studies provide few or no details of health surveillance programmes operating at a CHC. In addition, national variations in the programme content and timing

make assumptions about programme patterns difficult. Consequently, caution is needed in comparing the total number of visits with the number of visits required for screening and immunisations. Butler (DoH, 1989) in his review of health surveillance programmes concluded that there was a "skeletal consensus" in the literature for the previous 15 years. This is shown in Figure 3.2.3.

Figure 3.2.3: Consensus programme of screening - Butler (1989)

- neonatal (carried out in hospital)
- six weeks
- six-nine months
- 16-18 months
- 36 months

(Adapted from DoH, 1989, p 32)

In addition, there was the possibility of three CHC visits for immunisations in the first year of life, two more immunisations in the second year of life with a pre-school booster after the age of three years (DoH, 1989). Adding together Butler's surveillance programme and the standard immunisation regime suggests a possible five required visits by clients in the first year of the child's life and a possible four over subsequent years. These figures will be used as a guide to examine the frequency and the number of visits reported in studies.

There are weaknesses to this approach. First, although Butler (DoH, 1989) identifies a consensual programme, this does not preclude CHCs involved in studies carrying out different programmes, involving either more or less examinations, which might affect attendance patterns. Different programme content could lead to underestimating or overestimating the number of visits connected to screening tests or immunisations. Where studies identify the programme content details are given.

Second, the fact that a mother visits the CHC to receive an immunisation or a screening check for their child does not preclude them receiving a service from the HV. Third, clients do not necessarily attend for immunisations or for screening checks. These two factors might lead to underestimating the number of clients attending for services other than screening checks or immunisations. Finally, the fact that a client is not visiting the CHC for an immunisation or a screening check does not necessarily imply she receives a service from the HV.

An early study examining CHC attendance of 967 mothers in the first year of their infant's life reported 54% of mothers took their children eight or more times. Forty two per cent of mothers recorded twelve or more visits (Spence et al., 1954). Butler (DoH, 1989) reported that a study examining issues of cost effectiveness in general practice found 'many' clients attended CHCs for reasons other than screening or immunisations, although no number is stated. However, other studies provide additional evidence that screening checks and immunisations are not the only concern of CHC attenders (see Table 3.2.1).

Table 3.2.1: Studies identifying clients who saw the doctor at the child health clinic

Study	Clients who saw the doctor, including for screening of child	Clients who received immunisation at CHC
Acheson, 1962	5% (n = 13)	27% (n = 66)
McIntosh, 1964	9.5% (n = 100)	14.6% (n = 154)
Steiner, 1977	27% (n = 297)	n/a*
Morgan et al., 1989	51% (n = 283) *includes* 31% who had screening checks and immunisations.	n/a*

* = immunisation included in number who saw the doctor

None of the HVs in the above studies were described as having involvement in screening tests. McIntosh (1964) stated that some immunisations were given by the HV. These are not included in the immunisation figure in Table 3.2.1. In the remaining two studies, immunisations were given solely by the doctor. Therefore, the proportion of clients who received health checks and/or immunisations was in a range of 24.1% - 31%, which suggests most clients attended CHC for other reasons. Similarly, Morgan et al. (1989) note that under six months of age 16% (n = 38) of babies were taken weekly and a further 47% (n = 111) attended the CHC fortnightly. When the child was six months, the number of children attending decreased. Of those attending, over two thirds (67%, n = 105) visited six times or more up to the age of 12 months.

A weakness of this deduction is that attendance rates were estimates of frequency of attendance given by mothers, and therefore it is not possible to know whether mothers may have underestimated or over estimated visits to CHCs. However, the trend, particularly at certain periods of the child's life is for some mothers to be using the CHC more regularly than required by appointments for screening tests or immunisations. This trend is also

noted by Warner (1983) in her observations of CHCs and is revealed by While's (1986) examination of CHC attendance.

Contradictory findings were reported by Williams and Argent (1981) who noted the attendance patterns of 100 mothers and their babies in the first year of life in a CHC of a London practice. Just under a quarter (24%) of the sample attended 8 - 17 times, and 22% made between 5 - 7 visits. However, the authors reported a significant difference between first and second time mothers, with 66.7% (n = 16) of the former group likely to attend between 8 - 17 times in a year. This finding is supported by other studies (Graham, 1979; Morgan et al., 1989).

McIntosh (1992) whose sample was exclusively first time mothers, also reported high attendance rates. Sixty working class, primiparous women from inner city Glasgow were interviewed at two monthly intervals during the first nine months after the birth of their baby. Mothers were asked about their patterns of CHC attendance between the interviews. Nearly half (56%) of all visits (n = 533) were made during the first three months. This figure has additional salience as the author reports *no* visits for assessments or immunisations were made in the first three months.

Hart et al. (1981) also distinguished between visits that clients made for screening tests and immunisations and those made for other reasons. The authors' study took place in two experimental CHCs and one CHC that acted as a control. The study attempted to create an ideal CHC service to maximise attendance by all groups of mothers. Clients attended the experimental CHCs between 12 - 14 times (according to the CHC attended) in *addition* to screening checks and immunisations.

The full account of the study (Bax et al., 1980) also reports figures for the *control* CHC which had a mean of 10 visits not associated with test or immunisations, in the first year. The authors appear surprised by the rate of attendance within the control area as they comment (Bax et al., 1980, p 26):

> '*The use of the clinic in the control area is probably higher than in other less favoured areas of London and we feel this is largely due to the high quality of*

the nursing and medical staff at this clinic which has close links with St. Mary's Hospital.'

This may be the explanation, but without any evidence it remains an assertion by the researchers. If the excellence of the clinical expertise *is* the reason for the high number of attendances at the control CHC, it does not diminish the fact that clients attended on many occasions for reasons other than screening tests and immunisations in the first year.

These studies suggest that mothers attend CHC not only to receive screening tests and immunisations but also for other services. The proportion of CHC attenders for whom this is true appears to vary but it constitutes the majority of attenders in some studies. First time mothers appear particularly likely to attend for other services. Once the child reaches one year, attendance is generally much reduced for *all* CHC attenders.

Advice and support of parents had formerly been considered part of health surveillance (MoH, 1967; Committee on Child Health Services, 1976) but the research and debate on health surveillance has focused on efficacy of different screening programmes for many years (DoH, 1989). A more recent child health service review (Hall, 1996) recommended that this emphasis on detection of defects should change, and that child health care programmes should be broadened both in terms of underlying principles and content of the programme.

3.2.5 From child health surveillance to child health promotion

Hall (1996) argues for a shift in the relationship between parents and professionals involved in delivering child care. He suggests service orientation needs to reflect a partnership between parents and clinicians as opposed to professionals adopting a supervisory role. Thus, a child health programme would incorporate child health surveillance screening tests, but as part of *broader* child health promotion. Interestingly, these recommendations reflect Acheson's doubts 30 years earlier regarding the medical focus of CHCs (see 3.2.2).

The author (Hall, 1996) defines child health promotion as encompassing different levels of intervention (individual, community, government) and a wide range of issues (e.g. housing,

unemployment) that might affect the ability of a child or children to maximise their potential health status. Health education is viewed as an element of this programme incorporating giving health knowledge, including information pertaining to child development and management, but also consumer information and strategies to help people develop and maintain buffers against episodes of stress from whatever cause.

The report distinguishes between three levels of disease prevention possible in child health promotion: primary, secondary and tertiary (see Figure 3.2.4):

Figure 3.2.4: Levels of prevention - Hall (1996)

- primary prevention: reduction of the number of new cases of a disease, disorder, or condition in a population. (e.g. immunisations, advice and support for parents, dental prophylaxis)
- secondary prevention: reduction of prevalence of a disease, disorder or condition by shortening their duration or reducing their impact through early detection and prompt effective intervention. (e.g. screening tests)
- tertiary prevention: reduction of impairments and disabilities, minimisation of the suffering caused by existing departures from good health and promoting the adjustment of the child and parents to conditions that cannot be ameliorated

(Adapted from Hall, 1996, p 13-14)

Hall argues secondary prevention activities such as early identification of defects and disorders have previously been viewed as the central task of child health programmes. Whilst acknowledging their importance, Hall recommends that these surveillance activities should no longer take precedence over primary prevention. This shift to primary prevention provides grounds for the current study, which examines advice and support that clients might receive within the CHC. It satisfies both recommendations of the Hall report. First the advisory service is consumer led which fits well with principles of partnership and responding to client defined needs. Second, it provides the opportunity for examination of primary prevention instigated either by the client or the health worker.

Summary

During the 100 years that CHCs have existed they have acted as advisory centres for mothers with children. Initially, the services provided by CHCs were not mandatory and emphasis was on advice about infant feeding and nutrition. The emergence of developmental paediatrics saw an increasing interest in assessing the health and

development of children within the CHCs. Following the inception of the NHS, which formally required Local Authorities to provide CHCs, there was renewed interest regarding the type of service that should be offered within the CHCs. Child health clinics have also attracted a great deal of debate over whether the service should be a community service or based in primary care and who should be responsible for delivering the service.

Recent major reviews of health surveillance programmes have suggested a reduction in screening tests (Hall, 1989; Hall, 1991; Hall, 1996). In addition, it is argued that child health surveillance must move from its initial concern with secondary prevention and focus increasingly on primary prevention. It is recognised that as important as screening tests are, they are only one element of a preventive child health programme. The importance of working with parents, responding to their concerns and providing advice and support are now regarded as central to child health promotion (Hall, 1996).

Consequently, it is an apposite time to re-examine the work of the HV within the CHC, particularly with regard to the advisory role that she has traditionally held. Williams and Argent (1981, p 265) note:

> *'Mere numbers of contacts say nothing of their appropriateness. Help sought is not necessarily help received.'*

No assumptions can be made about whether the HV in CHCs is necessary to clients, or if perceived as necessary, whether the clients view this service as useful. Therefore, the remainder of the review will explore: to what extent if any, advice from a HV is a reason for mothers attending CHC, existing descriptions of the work of the HV in the CHC and studies which report clients' satisfaction with HV service in the CHC.

Section 3.3 Client reasons for attending child health clinics

It has been argued in Section 3.2 that most visits made by mothers with a child under the age of one year are *not* concerned with screening checks or immunisations. It has been suggested that whether or not mothers attend a CHC will depend on whether they judge that what CHCs do is important, and not available elsewhere (Graham, 1979; Karmali and Madely, 1985).

Orr (1980) reported that mothers who did not attend CHC in her study provided one or more of the following reasons: no perceived need (including screening checks), any potential need met by another service, and/or held negative perceptions about the CHC staff and/or facilities. Orr argues that (1980, p 65):

> *'It is in the utilisation of well baby clinics that the consumer can best exhibit demand for health visiting service.'*

In view of the assertion that perceptions of the CHC are linked with the use made by clients, it is useful to investigate the reasons clients give for attending CHC. Therefore, this section examines the main reason clients give for attending CHCs. This will allow comment on the extent to which the *health visitor* is perceived as offering a service to the client, and is selected as a reason for attending.

3.3.1 Weighing

Reasons for attendance at CHCs is one of the most frequent questions that clients are asked by researchers investigating the work of the CHC (e.g.: Acheson, 1962; Steiner, 1977; Orr, 1980; Sefi and Macfarlane, 1985; Biswas and Sands, 1984; Gastrell, 1986; Cubon, 1987; Sherrat et al., 1991; Sharpe and Lowenthal, 1992; Quine and Povey, 1993). The most common response from clients is weighing (see Table 3.3.1).

Table 3.3.1: Weighing identified as a reason for attending child health clinic

Study	Percentage of clients who give weighing as reason for attending CHC	Identified as most important reason for attending by client
Acheson, 1962ω *	45% (n = 110)	yes
McIntosh, 1964ω *	67% (n = 714)	not asked
Steiner, 1977	77% (n = 837)	not asked
Sefi and Macfarlane, 1985	64% (n = 642)	yes (by 12% of all clients)
Leggett, 1985	44% (n = 150)	not asked
Sefi and Macfarlane, 1987	69% (n = 56)	yes
Bolton, 1984*	67% (n = 186)	not asked
Biswas and Sands, 1984	84% (n = 78)	yes
Morgan et al., 1989Δ	10% (n = 57)	yes
Sherrat et al., 1991*	94% (n = 202)	not asked
McIntosh ,1992	75% of all *visits* (n = 533 visits)	not asked
Sharpe and Lowenthal, 1992	93% (n = 524)	not asked
Quine and Povey, 1993	95% (n = 738)	not asked
	Percentage of clients who give weighing as reason for last attending CHC	
Orr, 1980	95% (n = 59)	not asked
Quine and Povey, 1993	77%Φ (n =777)	not asked
Sefi and Grice, 1994	66% (n = 348)	not asked
	Percentage of clients who give weighing as a role of the CHC	
Karmali and Madeley, 1985*	83% (n = 59)	yes (by 67% all clients)
	Percentage of clients who give weighing as an expected and received service at the CHC	**Most useful service**
Gastrell, 1986	90% (n = 45)	yes (by 38% of all clients)

* = study had more than one group, figure given is an average of *all* responses.
ω = weighing *and* advice
Δ = weighing *and* social outing
Φ = approximate - figure taken from bar chart

In six of the seven studies where the researcher asked the client to identify the most important reason for going to CHC (Acheson, 1962; Sefi and Macfarlane, 1985; Biswas and Sands, 1984; Karmali and Madely, 1985; Gastrell, 1986; Sefi and Macfarlane, 1987), weighing was the most frequent response. All of the studies allowed multiple answers to the question 'why attend the clinic' either on a specific occasion or in general.

Three of the studies conflate weighing with another service obtained at the CHC (Acheson, 1962; McIntosh, 1964; Morgan et al., 1989). In consequence it is not clear in these instances whether weighing is a means to another end, rather than being valued as a service in itself.

One study (Cubon, 1987) not noted in Table 3.3.1 due to way the study was reported, refers to the importance of weighing to the client. In reply to parents being asked what 'they got' out of coming to the CHC, five main topics were described: reassurance about their child's progress 78% (n = 439), contact with other mothers, 25.4% (n = 142) advice and help with problems, 24.2% (n = 135) the opportunity to buy milk and baby foods 14.3% (n = 80) and a break from being at home 6.3% (n = 35). Cubon states that weighing is "frequently" given as the reason for attending but was coded as 'reassurance about child's progress'.

The implication is that some clients gave 'reassurance about child's progress' as a reason for attending but *did not* mean reassurance as a result of weighing. Reassurance in these cases presumably had some other interpretation. This may be linked to a specific service offered by the CHC such as developmental screening (which was highly valued by 74.4% of clients) or the reassurance may have come from discussion with the doctor or the HV. Due to a lack of information about the multiple meanings that were subsumed under 'reassurance about the child's progress' it is not possible to be clear what the importance of weighing was to the clients or the frequency with which it was chosen by respondents.

Field et al. (1982) interviewed 78 first time mothers and reported that weighing babies and the recording of the weights on growth charts was described by many women as the most important function of the CHC (no numbers reported). Moreover, Field et al. suggest that as anxiety about the child's weight and feeding declines so does the perceived usefulness of the CHC.

3.3.2 Social interaction

With the exception of the studies carried out by Leggett (1985) and Morgan et al. (1989) "to weigh the baby" is the most frequently recorded reason for attending CHC. Weighing is also chosen as the most important reason for attending or ranked as the most important service received in studies that ask this question. However, some researchers (Sefi and

Macfarlane, 1985; Sefi and Macfarlane, 1987; Sherrat et al.,1991) have suggested that this stated reason may conceal other intentions, chiefly the desire for social interaction, although other studies provide conflicting evidence (see Table 3.3.2).

Table 3.3.2: Social interaction as a reason for attending child health clinic

Study	Clients identifying social interaction of the CHC as a reason for attending
Biswas and Sands, 1984	10% (n = 9)
McIntosh, 1992	7% of *visits* (n = 39)
	Clients identifying social interaction of the CHC as a benefit
Sefi and Macfarlane, 1985	31% (n = 307)
Sefi and Macfarlane, 1987	40% (n = 32)
Cubon, 1987	25% (n = 142)
Sharpe and Lowenthal, 1992	3% (n = 11)
Quine and Povey, 1993	20%Φ (n =155)
Sefi and Grice, 1994	16% (n = 348)
	Percentage of clients who identify social interaction as a reason for *last* attending CHC
Orr, 1980	66% (n = 41)
Biswas and Sands, 1984	10% (n = 10)
Bolton, 1984 *	13% (n = 36)
Sherrat et al., 1991	9% (n = 21)
Morgan et al., 1989**	10% (n = 57)
Quine and Povey, 1993	7%Φ (n =54)
	Clients identifying social interaction as an *expected* service of the CHC
Gastrell, 1986	48% (n = 28)
	Clients who identify the social aspect as main reason for attending CHC
Karmali and Madeley, 1985	7% (n = 4)
Leggett, 1985	1% (n = 3)

* = study had more than one group, figure given is an average of *all* responses.
** = social *and* weighing
Φ = approximate - figure taken from bar chart

Sefi and Macfarlane (1985) reported a discrepancy between the reason mothers gave for attending CHC, and their responses to a question about the perceived benefits of the CHC. No mothers mentioned the social aspect of the CHC as a reason for attendance, but 31% of respondents gave meeting other mothers as a perceived benefit of attending. In a later study (Sefi and Macfarlane, 1987), 40% of the clients reported social interaction as a perceived benefit of attending.

Sefi and Macfarlane (1985, p 129) write:

> '*... the Oxfordshire survey suggest that for many mothers the child health clinic can provide an important additional social function. This, though, may not be initially revealed by the mothers, who use the popular reason for attendance of "weighing" as almost an admission ticket to the clinic. Many mothers could weigh their baby in the chemist shop, if not at home, but most appear to prefer coming to the clinic.*'

Cubon's (1987) study gives some support to these findings with 25% of respondents mentioning contact with other mothers as something that they 'got out' of attending the CHC. These studies point to the importance for some mothers of the social contact the CHC can provide.

However, other studies (Biswas and Sands, 1984; Karmali and Madeley, 1985; Sherrat et al., 1991; Sharpe and Lowenthal, 1992; Quine and Povey, 1993; Sefi and Grice, 1994) as shown in Table 3.3.2 indicate a much lower interest by clients in this feature of attending CHC. Consequently, it is not possible to say that clients *generally* appear to view social interaction as an important aspect of the CHC visit. Arguably, whether the CHC is perceived as a social outlet will depend on characteristics of the CHC and needs of a local population, and that these will vary (Williams, 1991).

Orr (1980) also commented on the possible relevance to clients of weighing. Asked why they had last attended the CHC, 95% of clients mentioned weighing and 66% of participants said to meet other mothers. Orr cites Rosenstock's argument that there must be a trigger for a client to use a preventative service. Orr writes (1980, p 67):

> '*In the case of well baby clinics, the stimulus may be manifest, as in the provision of weighing facilities, or latent as in the seeking out of social contact.*'

On the basis of the above evidence, Orr's (1980) suggestion that CHCs best demonstrate a demand for health visiting service may not mean very much. If the health visiting service

in the CHC is restricted to weighing a baby or child, this may represent a rather insignificant professional role.

Summary

The evidence to suggest social interaction as a significant reason for mothers to attend CHCs is mixed. By contrast, weighing is the most common reason clients give for attending CHC. Several studies have found that clients regard this as the most important aspect of their visit.

The notion of weighing as a "trigger" or "an admission ticket" implies that the act of weighing should not be seen as an end in itself but rather a means to an end. As a trigger, weighing can be viewed as a stimulus that encourages people to attend CHC where they can access other elements of the service. As an admission ticket, weighing may be just a convenient general reason provided for going to the CHC and may obscure other intentions that the client has. It is of some interest to examine whether the HV is perceived as contributing to other activities aside from weighing. The Court Report (1976) made the observation that non-attenders at CHC may not identify the HV as a specialist source of advice and support in the care of babies. It may be that the same observation holds true for those who do attend CHC. In order to examine this point, studies which have attempted to provide descriptions of the work of the HV in the CHC are examined in Section 3.4.

Section 3.4 Descriptions of the work of the health visitor in the child health clinic

The work of the HV in the CHC is part of the child health promotion programme. It appears from the literature the focus of research has primarily concerned the screening service offered children (e.g. Committee on Child Health Services, 1976; Illingworth, 1979; Zinkin and Cox, 1979; Hendrickse, 1982; Nicoll, 1983; DoH, 1989; Barnes, 1992; Fagan, 1997).

This focus on the screening element of the child health promotion programme may account for some of the difficulty in establishing the HV's contribution in the CHC. Screening checks have been predominantly, although not exclusively, carried out by medical staff. If these tasks are perceived as the important work of the CHC, it would explain the tangential reference to health visiting activity in studies about CHCs. In addition, when descriptions

of the work of the HV are available these often lack clarity because of poor methodological construction. This section will examine these problems associated with identifying HVs' work in the CHC.

3.4.1 The problem of identification

Empirical studies tend to focus on the work of the doctor. When the work of the HV is alluded to, the description is so limited that it is difficult to assess what contribution, if any, she makes. An example of limited reporting of the HV can be found in Steiner's (1977) evaluation of CHC services in Newcastle. Steiner twice mentions the HV was doing most of the work in the CHC. He reports that 73% of the sample *saw* the HV only and the majority (77%) of women brought their children to be weighed and that weighing (Steiner, 1977, p 3):

> *'Provided an opportunity for the health visitor to give advice, support and reassurance about the everyday problems of children and their families, such as the parents' adaptation to a new baby, feeding difficulties and behaviour problems.'*

It is not clear what seeing the HV involved. The inference is that the HV weighed the child and thus was able to offer advice during this process.

Weighing *may* have provided an opportunity for the HV to give advice but the study cannot show how often if at all, this occurred. Description of the HVs' activity can only be assumed from clients' responses regarding why they attended the CHC. None of the categories are specifically mentioned as issues that were dealt with by the HV. Steiner assumes that the act of weighing necessarily involves advice but this is not borne out by the reasons given by the client for attending the CHC or by any other evidence. By contrast, the reasons that mothers consult doctors is described together with a list of problems identified by medical practitioners. Details are also provided of the morbidity identified in children who underwent screening by doctors.

If the HV is carrying out most of the work in the CHC then any evaluation of CHCs needs to include an adequate description of that work. It could be argued that although the HV is doing most of the work, such work is so unimportant in terms of level of expertise and

impact on the mother and child that it is not worthy of investigation. However, such a conclusion would have to be based on a clearer picture of HV activity than Steiner's.

Another study which asked clients why they attended the CHC (Karmali and Madeley, 1985) also failed to identify HVs' services. Weighing, checking progress/development, advice about care/worries, injections/immunisations and help with medical problems were selected as reasons for visiting, but the general nature of these descriptions does not allow any comment on the extent, if any, to which the HV featured in these activities.

The HV *is* referred to several times in the study. Six infrequent attenders gave as a reason for not attending CHC regularly the fact that they saw their HV at home. The implication was that for at least six out of the total of 71 participants, CHC visits featured involvement with their HV. Five clients mentioned not seeing their own HV at the CHC as a negative aspect of attendance. The authors found a statistically significant difference between clients attending the CHC according to whether their HV worked there. The study, while suggesting the relationship of the HV with the client may have an effect on attendance at the CHC, does not tell us the nature of the contact between the client and HV at a CHC. This is perhaps understandable as the primary purpose of the study was to investigate mothers' attitudes to CHCs. However, interpretation of consumer studies may be limited in terms of analysing service delivery if features of the service, including the contributions of various health workers, are not described, or cannot be linked to clients' reports of the service.

A further consumer study which tells us little specific about the service is provided by Cubon (1987). The author asked 592 parents "what they got" out of coming to the CHC. Four main topics emerged: reassurance about their child's progress 78% (n = 439); contact with other mothers 25.4% (n =142); advice and help with problems 24.2% (n = 135); opportunity to buy milk and baby foods 14.3% (n = 80); break from being at home 6.3% (n = 35). In terms of identifying HV input, this *may* be reflected in advice and help or reassurance about their child's progress. However, in addition to HVs, all the 12 CHCs in the study had a doctor working in the CHC who was also available for advice as well as for screening tests. Therefore, attributing benefit to the HV rather than the CHC doctor or indeed another mother is impossible.

These three studies produce findings that give information about why clients attended CHCs, but do not identify the HV with a particular service for the client. When studies do make a link with a CHC service and the HV, methodological weaknesses produce further difficulties with interpretation. Commonly, categories distinguish between the client receiving advice, and the client's interaction with the HV. This creates an impression of the discussion with the HV constituting a social occasion rather than a professional consultation. It may be that both descriptions fairly describe the work of the HV. If that is so, then the benefit, if any, of a social relationship with the client needs to be explored. A social role may underpin other services and be the medium through which the HV is able to offer advice and information on other occasions. Alternatively, it could be that a social interaction with the HV actually has no value for the client.

3.4.2 Seeing the health visitor

An illustration of the difficulty in understanding the HV's role due to ambiguous categories is provided by Biswas and Sands (1984). These researchers investigated why clients came to CHCs and whether the service was meeting their needs. Mothers reported 'weighing' (84%) and 'advice' (6%) as the most important reasons for attending the CHC. The second most important reasons for visiting were 'advice' (24%) and 'to see the HV' (15%).

Where the clients selected 'advice' we cannot know from whom they were seeking advice. When 'to see the HV' is given as the reason for attending it may describe seeking advice but this is uncertain. Given that the questionnaires were not postal it is unfortunate that no further information was gained to clarify what 'to see the HV' actually meant. This might have increased our understanding of the function of the HV as perceived by mothers.

Confusion also arises where studies have different descriptions of HV activity without defining what each activity is, or the difference between them. Orr (1981) reported that 62 of her sample of 68 women had attended the CHC. Eleven (18%) of 62 mothers women selected 'for specific problem with HV about baby' as a reason for their last CHC attendance. However, a further 31 (50%) mentioned 'general discussion with the HV about the baby'. The latter reason is not necessarily concerned with advice giving and we can have no idea of the nature of the service being provided to the client.

In another similar example, Sharpe and Loewenthal (1992) investigating reasons for attendance at GP or Health Authority CHC, reported that two of the reasons given by the clients for attending either type of CHC were: 'discussion with the HV' (44.5%) and 'advice from the HV' (39.1%). It is difficult to know from the report in what way 'discussion' may differ from 'advice'.

Another study (Morgan et al., 1989) also provides two types of inadequately defined descriptive categories for the client speaking with the HV: 'To see HV for a chat', 'To see HV for a specific problem or question'. Twelve per cent of the sample gave the former as their main reason for attending CHC and 33% of the respondents gave the latter.

The authors report that 45% of the mothers said they were attending to see the doctor. However, the authors note that of the group attending mainly to see the doctor, 33% had questions they wanted to 'discuss' with the HV. If 'discussion' is interpreted as seeking advice rather than a 'chat' the number of mothers attending to seek advice on a specific problem or question rises to 48%. Attempting to estimate how many clients wanted to see the HV is further confused later in the text (Morgan et al., 1989, p 245):

> *'The organisation of the clinic meant that although 10% of people had come to the clinic just to weigh their baby and have a outing, almost one half of this group saw the health visitor ... Thus overall 94% of all attenders saw the health visitor while 71%* [my emphasis] *wanted to discuss a specific question.'*

The authors give few details of how the figure of 71% is deduced from the data. Participants completed a form at the beginning of the CHC visit which noted their reasons for attendance. A second form at the end of the CHC visit recorded services actually received. This may have provided the research team with their figure of 71%. However, in the table that provides details of the percentage of different issues discussed, the issues are described as ones that participants *intended* to discuss. Additionally, the total percentage of mothers who intended to consult the HV shown on the table is 64% rather than the 71% reported in the text. Inadequate reporting of the method and problems with interpretation of the tables and the text limits the study.

These findings from Orr (1981), Morgan et al. (1989), Sharpe and Loewenthal (1992) suggest that some clients are using the HV, but there is a lack of clarity about the interaction between client and HV due to ambiguity of the category descriptions. The studies raise questions about the difficulty in understanding what a respondent means by a description.

A final example of how a variety of descriptions may obscure rather than clarify the actions of health workers is provided by Gastrell (1986). The author asked a sample of 50 mothers who had attended CHCs what services they expected, and received, and which service they ranked as most useful. There are three specific descriptions of expected HV activity in Gastrell's study: 'to talk to the HV about the baby/children', 'to talk to the HV about personal matters' and 'to talk to the HV about family matters'. Talking to the HV about the child or other children was ranked most important by seven people although *received* by 32. The other two HV categories were not selected as the most important by any participants.

Weighing was the most expected service and ranked as most useful. Joint second most expected services were 'confirmation of babies' 'progress' and 'advice - i.e. about feeding'. There is no way of establishing to what extent, if at all, the HV contributed to these activities because the author does not report which health worker provided any of the services. Similarly another category of 'advice about particular problems - sleeping, teething, etc.' may have referred to advice by doctors or HVs.

The most reported useful services are 'monitoring of child's height and weight' and 'confirmation of babies' progress'. The process of weighing and confirmation are not clear, and do not necessarily suggest the HV was an important feature of these activities. In her discussion, Gastrell comments that from discussion with the mother it was apparent weighing involved more than 'a mere recording of weight' (Gastrell, 1986, p 79). However as she gives no further details it is impossible to tell if this process involved a contribution by the HV or that the act of weighing had a resonance for the mother not necessarily captured by the description of weighing.

Gaining advice is potentially described under several categories. There are separate categories for 'advice', 'teaching on health matters' and 'talking'. Therefore, a query arises over the nature of the exchanges that took place. It could be, for example, that 'talking to the HV about the baby/children' may have been more of a social chat, an informal exchange rather than a discussion reflecting or necessitating professional expertise. Gastrell comments herself that the ambiguous and indirect way of approaching health education practised by some HVs may prevent clients actually noticing information that has been offered. Gastrell's study presents another confusing picture of the work of the HV, with three varieties of category of talking to the HV and two separate categories of advice giving.

Many studies seeking to provide details of HVs' work lack descriptive power because of failure to clarify what particular categories refer to, or to link the HV with a particular service. A similar problem is found if investigators introduce terms in their report without adequate explanation. Bolton (1984) reported the views of 278 clients attending three CHCs in different locations. When asked why they attended, the majority (66% - 69%) reported they attended to have their child weighed. Advice from the HV was given as a reason by only between 16% - 34%. One of Bolton's conclusions was that the study demonstrated the importance of weighing to the client. However, 94% - 98% were described as having "consulted" the HV when they went to CHC. Bolton (1984) comments twice that almost all the attenders had seen the HV. Knowing that the HV 'saw' the client does not tell us what this involved. It is not possible to tell what the inference can be validly drawn regarding the HV service.

Observation of the process of the mother having the child weighed would have provided grounds for assessing whether consultation with the HV resulted in the client receiving advice and information even though the mothers had not attended the CHC for that specific purpose. Alternatively, it could mean that using the word 'consulted' simply describes the process of getting the baby weighed by the HV. Adequate information about the service that the mother received is necessary in order to assess if client's reasons for visits necessarily provide an accurate reflection of the service they receive.

Bolton's method of reporting may inflate the HV's contribution to mothers but it is also possible it underestimates HV activity. The author needs to explain what 'consultation' involves in order to establish, as she implies, weighing is the most important aspect of the visits.

A similar problem arises in McIntosh's (1964) study which assumed certain actions occurred without providing evidence to support these assertions. The survey examined the use made by mothers of facilities offered in urban and village CHCs. The facilities available in both areas were: food, weighing, HVs' advice, immunisations, doctors' advice.

In order to avoid making recording of data too onerous for HVs, weighing and HV advice were combined into one service. The HV did not weigh the baby in every CHC in the study, but stood near the scales or spent time talking to mothers in the CHC. McIntosh reasoned that if a mother had a baby weighed, she automatically received advice (McIntosh, 1964, p 219):

> *'It is assumed that every mother made verbal contact with the health visitor at some time during the session. There is no real dividing line between advice and non-advice in a conversation between the HV and the mother; thus a simple statement of a satisfactory weight gain could be taken as advice to the mother concerned that she is coping adequately with the job of bringing up her child.'*

Health visitors recorded that of 714 mothers' who received 'weighing/health visitor', only 15 came for advice from the HV with no weighing involved.

However, we cannot know whether the 699 who either had a baby weighed by the HV or with her in the vicinity, received more than the knowledge of that weight. Moreover, Mcintosh provides no grounds for his assumption that every mother spoke to the HV. In addition, the notion that there is no real dividing line between advice and non-advice could suggest that the HV's role as advisor does not involve more than telling the mother the weight of her child. Some more sensitive measure of the extent of the 'advice' given (if any), is essential.

The rationale for considering HV advice and weighing as synonymous, is very similar to that provided by Acheson (1962) in an earlier study. Acheson interviewed 245 mothers in three different areas of England and Wales about their attitude to CHC services. He noted that if the clients said that they had attended the CHC that day for 'advice', it always meant from the HV, and was mentioned by 40 respondents. A further 110 gave weighing as the reason for attending. Acheson comments (Acheson, 1962, p 1356):

> *'the weighing of a baby involved more than making a simple observation about its size. It was a conversation piece during which the mother <u>often</u>* [my emphasis] *took the opportunity to discuss some minor skin blemish with the health visitor or to question her about a matter of feeding or general management. Thus since advice <u>often</u>* [my emphasis] *involved weighing and weighing advice, it seemed logical to combine and describe them as "health visitor service" .'*

Acheson does not say how he reached the conclusion that weighing often provided the opportunity to discuss something with the HV. There is no mention of whether researchers were observers in the CHC in order to gain information about what happened during the process of weighing. Interestingly, Acheson reports that the advice aspect of his definition of HV service always involves advice *in addition* to recording the child's weight, whereas Mcintosh views the HV telling the mother the weight as advice. The intention of Acheson was to examine consumer attitudes. What the study does is to demonstrate professional assumptions of the nature of the interaction between the HV and the client.

The 40 clients who reported advice as a reason for attending the CHC may have been seeking a qualitatively different service from the 111 who mentioned weighing as the reason for attending. The study cannot assume that these consumers perceive both services as equivalent. Chatting with the HV about a baby related issue may be the price that these women had to pay in order to get the child weighed.

A number of problems in terms of the description of the work of the HV have been examined. They have included: poorly defined categories that have limited explanatory power regarding the nature of the HV service, failure to link services with HVs,

assumptions that reasons selected by clients for attending the CHC equate with services received. Furthermore, asking clients why they attend seldom identifies the HV as a reason. However, in three studies which asked mothers to select the perceived benefit of attending CHC the HV emerged as a strong factor.

3.4.3 Health visitors as a perceived benefit of the child health clinic visit

Sefi and Macfarlane (1985) attempted to clarify some of the issues surrounding HVs and their advice role in the CHC. In their study, weighing is given as a main reason for attending by most mothers (64%). The authors also asked clients the perceived benefits of attending the CHC. Weighing was not mentioned, although there was description of 'reassurance' (49%) and 'general check' (28%) either of which might refer, at least in part, to weighing. The descriptions 'reassurance' and 'general check' may also refer to the effect of advice, comment or information from the HV or the doctor. They are, however, very general.

Advice from the HV was specifically mentioned and rated a benefit by 48% of attenders. It is interesting to note that only 17% of the sample put 'to see the HV' as a *reason* for *attending* the CHC. Sixty two per cent of clients in a later survey reported HV advice as a perceived benefit of CHC visits, although only 22% gave this as a reason for their last visit (Sefi and Grice, 1994). 'Reassurance' (52%) and 'general check' (61%) were again described as benefits while weighing was not reported. These studies demonstrate the dangers of extrapolating actual service received by clients from reasons given for attendance. However, it is possible that the discrepancy indicates that clients selecting weighing as the primary reason for attending anticipate this will *also* include a discussion with the HV. Alternatively, it could suggest that the HV is extremely successful in proactively raising issues with clients once they are in the CHC.

Another study by Sefi and Macfarlane (1987) interviewed participants who had attended HV advisory CHCs which had no doctor present. Half the mothers gave to see the HV as a reason for attending the CHC, in contrast with 17% of the sample in the previous study. Advice from the HV was mentioned as a perceived benefit by 45% of the sample, similar to the earlier study's 48%.

The final example of a study which investigated clients' perceived benefits is provided by Sutton et al. (1995). This study differed from Sefi and Macfarlane (1985; 1987) as clients were not asked reasons for attendance and therefore no comparison could be made with the perceived benefits. In addition, the CHC users had to select up to five aspects of child health surveillance which they perceived as benefits from a list of 13 aspects. Immunisations were chosen most frequently (75.9%), followed by over two thirds (68.1%) of parents selecting discussion with the HV.

Client reports of the benefit of CHCs imply that the HV provides a larger contribution to the CHC service received by mothers than suggested by other studies (Sefi and Macfarlane, 1985; Sefi and Macfarlane, 1987; Sefi and Grice, 1994; Sutton et al., 1995). Few studies have investigated the details of conversations between HVs and clients. For example, Sherrat et al. (1991) reported that 50 % of their sample (n = 228) selected discussion with the HV as their most important reason for attending the CHC. No details of the nature of the discussion held between parent and HV were provided. This is important for a number of reasons.

First, the different categories used in some studies to describe HVs and clients talking suggest that at least some of the interactions may be of a general nature with no requirement of advice or information from the HV. If this is so, the role of the HV in the CHC may need to be re-examined. Second, if the HV is a source of advice and information then evidence of this should clarify the role of the HV, and provide knowledge of consumer needs. Finally, adequate description of this activity will facilitate investigation of the outcome of discussions between client and HV.

3.4.4 Topics discussed by the health visitor

There is limited information regarding the number of topics discussed between clients and HVs and the nature of the discussion. Watson (1981) was a non-participant observer in 14 CHC sessions, but did not provide details. Warner (1983) who observed HVs in 12 CHCs sessions, noted physical care of young children especially feeding were the most commonly discussed topics. The author noted that discussions lasted an average of eight minutes. An earlier study (Marris, 1971) recorded the number of topics discussed between

HVs and clients. However, Marris (1971) provided the number of topics for *all* CHC work and did not differentiate between topics discussed in CHCs, and in other types of clinics.

Investigating the content of discussion between the HV and client is not unproblematic, as Leggett's (1985) study demonstrates. The author reports 53% of respondents stating they were attending the CHC to get advice from the HV. Clients were followed up offering a potential opportunity to discover what issues were discussed and how clients evaluated this HV intervention.

However, there is some confusion with regard to the aim of this follow up study. In the abstract, Leggett writes that she wants to look at the advice *given* by the HVs in the CHC. In the text, she says the aim was to find out what information was *sought* by families when they went to the CHCs. Information given by the HV does not necessarily correspond to the information sought by the client. Clients may be getting information that they do not want or require.

The HVs recorded information that they *gave* to clients, 156 items of information about children, and five items of information for parents was recorded. A mean of 1.5 topics was discussed with each client (Table 3.4.1).

Table 3.4.1: Topics discussed between client and health visitor (Leggett, 1985, n = 156)

Topic	Number of clients
feeding	60% (n = 95)
child development	41% (n = 65)
family planning	3% (n = 5)
immunisation	13% (n = 21)
Other included: general management nappy rashes bowel problems heat problems sleeping pattern toilet training footcare speech and hearing head infections social problems including housing and legal advice depression (n = 1)	29% (n = 46)
Total	**232**

However, we cannot tell whether the topics recorded are ones that the client sought information about or topics that the HV decided they should know about. We are told that 13% of advice concerned immunisation information. It would be useful to know whether that was linked to immunisation sessions. Similarly, with child development information, we do not know whether this was linked to the assessments being carried out by the doctor in the CHC. In these cases it may be that the HV provided the information as part of the process of these screening checks.

There may be correspondence between information that HVs think clients needs and information clients actually seek but this is not necessarily so. In carrying out a report on *consumer* perspectives it is important not to confuse the two. Because of this flaw, this paper cannot actually tell us what information families did seek and cannot give any idea about the effectiveness of the HVs in respect to this activity.

Similar confusion arises in Morgan et al's. (1989) study which suggested that HVs may be a source of advice for mothers. Morgan et al. (1989) reported the reasons that clients gave for intending to consult the HV (see Table 3.4.2).

Table 3.4.2: Reasons for consulting the health visitor in the child health clinic (Morgan et al., 1989, n = 566)

Reason for consultation (intended)	% of mothers
Concerns about weight, progress, feeding, sleeping	24
Concerns about behaviour	12
Physical health problems	18
Immunisations and checks	5
Social problems	2
Other	3
Total	**64%**

(Adapted from Morgan et al., 1989)

The authors also listed the clients' intended reasons for consulting the doctor and report what clients actually did see the doctor for in terms of advice and services. However, the information we are given about HVs is restricted to *intentions* of the client. There is no report of what they actually discussed with the HV. The figures reported are difficult to interpret but on the basis of Table 3.4.2, 64% of the sample may *either* have intended to consult or consulted the HV.

Hart et al. (1981) asked 158 mothers, who between them attended two London CHCs, what they had discussed or sought advice about during CHC visits. The mothers were asked this in regard to visits made during the previous year. The authors had noted earlier that the majority of visits made to the two CHCs were *not* connected to screening checks and on such occasions mothers 'always' saw the HV and 'often' the doctor. Therefore, it would have been useful to examine the contribution of the HVs to the clients' well-being as they apparently were seeing some women frequently, particularly in the first year of life. In one of the centres women came approximately 14 times, and in the other approximately 12 times.

However, when the women were interviewed about the advice sought and discussed at the CHC, no distinction was made between whether the HV or the doctor was involved. The authors judged it would be too long after the event for the client to recall. However, they make no comment about the possible effect on the recall of advice or discussion held. The authors examined the reasons for consulting the doctor in the CHC but there is little

comment on the work of the HV. Interestingly, the authors note (Hart et al., 1981, p 444):

> *'It is evident that parents found the doctor's advice valuable by the frequency with which they returned before the next check was due.'*

This ignores the possibility that clients are returning before the next check because they are receiving a service from the HV. The effect of the study design utilised by Hart et al. (1981) is to obscure any impact made by the HV on client well being or satisfaction with services.

The majority of visits in this study were made by mothers who were not attending for routine screening. The authors imply that the HV as well as the doctor is frequently seen during these visits. Although consultations with the doctor are investigated and described, the work of the HV is not.

It could be concluded that the only important source of advice and information for mothers in the CHC is the doctor. If so, it would be timely to consider what the role of the HV is in the CHC. However, such a conclusion needs to based on evidence of what HVs are doing. Therefore, a focus on the work of the HVs needed to balance the accounts of CHC activity by doctors. In multi disciplinary work it may be hard at times to unravel the influence of particular workers. Notwithstanding this difficulty, HVs need to try and identify more closely any contribution they make.

Summary

The work of the HV in the CHC is not clearly described. There is an assumption by some authors that if the HV weighs a child the mother receives advice. Other studies present multiple categories of advice giving so that it is unclear from whom the client receives advice. In addition, some of the descriptions of the client's interaction with the HV suggest that it may be a 'chat' rather than the mother seeking professional help. The extent to which the HV is seen as an advisor varies widely between studies. Only one study reports the number of topics discussed by the client with the HV or provides details of these topics.

Section 3.5 Client satisfaction with their child health clinic visit

It has been suggested that measuring client satisfaction with services is valuable for a number of reasons. Donabedian (1992) argues that any attempt to measure quality of care must include information about clients' perceptions and expectations of that care. Satisfaction can also be viewed as an outcome of care insofar as it is an aspect of clients' well-being (Donabedian, 1992; Barribal and Mackenzie, 1994). Speedling and Rose (1985) note several studies which report that high satisfaction rates with medical care are related to increased utilisation of services. Client satisfaction may be used as a means of evaluating a particular service and the personnel involved in that service (Merkouris et al., 1999).

This section describes several studies that have sought to examine client satisfaction with CHC services and notes two problems. First, there is a lack of precision in the measurement of clients' satisfaction levels. Satisfaction is not clearly defined within studies. Therefore it allows limited comment on the service or clinical staff under evaluation.

Second, at times there is a failure to separate work of the HV from that of other CHC staff and from other CHC activities. Many studies reporting satisfaction levels of clients cannot tell us about satisfaction levels *with* the *HV* because they do not discriminate between the different workers or different activities. Consequently, it is frequently difficult to establish either the nature or the outcome of encounters between the HV and client in the CHC. These points will be examined and discussed below.

3.5.1 Studies that fail to identify clients' satisfaction levels

Some studies which seek to investigate satisfaction possess a weak methodological construction which hinders such an examination. The result is that the author refers to satisfaction levels which are not founded on any evidence produced by the study.

Leggett (1985) states she is attempting to assess whether clients' needs were satisfied by professional and ancillary staff in the CHC. The six questions asked of the client are shown in Figure 3.5.1.

Figure 3.5.1: Questions asked by Leggett (1985, n = 158)

1.	Reasons for attending clinic.
2.	Age of baby.
3.	What do you think the health visitor is?
4.	Where would you rather attend?
5.	Regularity of attendance.
6.	Any other changes in the clinic?

Apart from last question, there is no possibility in the question structures of finding out from the consumer what they think of the services they receive and whether the professionals and ancillary workers are in fact satisfying their needs. Question six does not ask the client for feedback about the service they receive from health staff in the CHC.

Despite this, the author reports the clients on the whole seemed to be very satisfied with the service. She lists three comments about improvements that were suggested by clients which are provision of a notice board, sale of tea and improvement of air conditioning in one health centre. The statement about adequate service is again made although this time it is modified (Leggett, 1985): "On the whole the public seem to be *fairly* satisfied with the service they are getting". It is impossible to know what these assertions about satisfaction are referring to although from the examples given they appear to be concerned with structural issues to do with the CHC as opposed to the service delivered by the staff. Leggett's study cannot answer its aim of examining whether professional and ancillary workers were satisfying the needs of their clients.

Like Leggett, Bolton (1984) investigated mothers' use and opinions of CHCs. The study arose from the desire of HVs to establish whether clients were satisfied with the service and how the CHC could be improved. Mothers who attended three CHCs in were interviewed (n 278). Mothers were asked whether they were satisfied with staff *other* than the HV and doctor. The clients were also offered a list of five facilities and asked which one they would most like to see introduced or whether they felt that the CHC was satisfactory as it was now. The pre-determined choices were: an appointment system for the doctor, cups of tea, play material for children, health education material, access to a social worker.

It is interesting that although the motivation for this study arose from HVs, the design of the study pays little attention to describing or evaluating their role in the CHC. Bolton does not see this as problematic (Bolton, 1984, p 43):

> '*Almost all the attenders had seen a health visitor and considered the purpose of their visit had been achieved.*'

The author does not provide evidence for this assertion. The aim of the study was partially to discover satisfaction with the service. However, in terms of health visiting activity, the only question directed at this service is whether the HV spent enough time with the mother.

Although both these studies purport to attempt to establish whether the CHC met mothers' needs, the question design restricted the focus of replies to structural issues and permits extremely limited comment by clients on their experiences of the HV. Similarly, questions that are too broadly focused also produce problems with the validity of their findings. Questions which invite general comments may reduce the response rate, and be unable to identify the factors which lead to clients' satisfaction or dissatisfaction.

3.5.2. Studies asking general questions about clients' satisfaction levels

The problems of interpretation that arise from general questions regarding satisfaction can be seen in a study by Sherrat et al. (1991). The authors asked 228 women about several aspects of their experience of parenting including attitudes to the child health services. When the authors attempted to measure clients' satisfaction with the service, they simply asked clients to comment on the services provided. The majority offered no comment (53%). Forty seven percent responded, of these, 20% reported negative comments and 27% gave positive comments. There is no discussion of this issue by the authors. The reader is simply told that the critical complaints included lack of frequency of *home visits* by HVs, lack of time in CHCs and lack of information at screening sessions.

The positive comments are even more vaguely reported. The authors write (Sherrat et al., 1991, p 86):

> '*Typical of comments from the 25%* [error in original paper] *who made a positive statement was: "I am very satisfied with the service I have encountered and have great confidence in my health visitor.... She is always ready to listen, which I think is important.*'

This study indicates the problems that arise when enquiries about satisfaction are not made in a specific way. Vague question construction may encourage people not to respond, particularly if, as in this case, a self administered questionnaire is used, since there is no opportunity for follow up probe questions to prompt a response or address any confusion on the part of the respondent. If the response rate to a question is low, as in this study (47%), problems of representativeness with any responses will arise. If nearly half of the clients do not reply, it is impossible to know to what extent either the positive or negative responses are representative of the total sample. Additionally, if respondents are asked to comment about any aspect of a service, clients may respond about a number of different issues. Inevitably this will reduce the response rate for any one particular issue, further reducing the confidence we might have in any conclusions drawn about it.

Biswas and Sands's (1984) study also illustrates the difficulties that arise by asking non-specific questions regarding satisfaction. They state that one of their research questions was to examine whether the CHC met mothers' needs. There is a lack of description about the means the authors employed to meet the aims of the study. No statement of the question used to elicit this information is reported. In the results section the authors say that the mothers were invited to comment on the CHC and child health service *in general.* A general question might not result in appraisal of the *child health clinic* as opposed to a question which invites the participant to comment on specific aspects of a service.

Interestingly, 11% of clients did not reply to the invitation to comment about the service. We cannot tell whether that indicates satisfaction or the reverse. Although 61% of the 89% who did reply are described as satisfied, there is no description of the response of the remaining 28% who also responded to the question. In the light of the 11% of the total

sample who did not comment it could be that nearly two fifths of the respondents were *not* satisfied. These reports of satisfaction rates are vague and unhelpful in terms of evaluating health visiting or other aspects of the CHC service.

Dworkin et al. (1990) in contrast to the studies previously described, asked *specific* questions of mothers regarding satisfaction with the child health service. The authors suggest that the child health programmes have to meet the expectations and desires of parents. They argue that unless this happens, compliance by parents with preventative health measures or programmes may be poor. As a consequence they suggest we can use parental perceptions of child health services as an indirect measure of quality of care.

If we ask parents what they think of a service, they may include evaluations of the service providers or service structure that enables other commentators to share or disagree with their assessment. However, in making these evaluations, clients may have low expectations due to previous poor service, a limited perception as to the rights they have with regard to a particular service experience, or a fear that negative comments may affect their access to services in future. Clients may also be unable to assess certain elements of a service because they lack the skills or knowledge to do so.

Therefore, the use of clients' perceptions as an indication of quality of service is not without its problems and needs to be approached sensitively. Mothers were asked to rate their responses on a scale of 1 (highly dissatisfied) to 5 (highly satisfied). The use of a rating scale increases the ability of the researcher to compare responses. Mothers were asked about (Dworkin et al., 1990, p 340):

- mother's ease with asking questions
- provider's explanation of issues
- provider's concern for mother
- provider's concern for infant
- helpfulness of provider's advice
- mother's comfort with provider
- thoroughness of examination
- provider's skills

The last two issues examined are examples of activities which mothers may be restricted in their ability to fully comment upon.

Dworkin et al. (1990) stated that the high degree of satisfaction with all these elements of the service corresponded with the results of other studies. However, the studies that Dworkin et al. quote did not incorporate such defined notions of satisfaction. These studies describe a *general* notion of satisfaction such as that found in Sharpe and Lowenthal (1992) with their general question of satisfaction with the CHC service.

Sharpe and Loewenthal, (1992) stated that one aim of their study was to assess whether the clients were satisfied that the service met their felt needs. Nine reasons for attending the CHC are identified by clients, two of which include the HV 'discussion with the health visitor' (44.5%) and 'advice from the health visitor' (39.1%). To examine whether any of the nine reasons or felt needs were met, mothers were asked whether they were satisfied with the *service* they received at the CHC. The rationale for using this approach is derived from Dworkin et al's (1990) study.

Sharpe and Loewenthal write (1992, p 351):

> '*If it is accepted that reported levels of satisfaction with a service are an indirect measure of the quality of the service as purported by Dworkin et al. then it is reassuring that 91% of respondents were either satisfied (51%) or very satisfied (39.3%) with the service that they had received at clinic.*'

Sharpe and Lowenthal's (1992) study asking clients to comment on the service at the CHC does not have the same ability to describe *features* of the service as Dworkin et al. (1990). In the former case, it is not clear which elements of the service clients were referring to. The satisfaction ratings may not be describing the same elements of the service for each client.

Sharpe and Lowenthal note that only seven percent of respondents described themselves as dissatisfied. When invited to make comments regarding improvements, 44% of people

made suggestions. How do we understand these suggestions with regard to the previous complimentary satisfaction rates? Sharpe and Lowenthal suggest (1992, p 351):

> '*This additional data helped to provide a much greater picture of how the "felt needs" of the users were being met than if simply taking the reported 91% satisfaction rate at face value.*'

If 44% of people made suggestions for improvements it is difficult to understand in what sense this gives a better idea of how the client's 'felt needs' were being met. It could be that despite the high satisfaction rates, there were significant areas of 'felt needs' that were *not* being met. This would suggest a lack of sensitivity of their measurement of satisfaction. If the reported satisfaction rates are unproblematic, perhaps these suggestions for improvement are not seen as important by the clients. If they *are* seen as important, then the 91% response rate of satisfied or very satisfied clients is not necessarily an adequate indicator of quality.

Just as a general enquiry about satisfaction with services will result in poor and limited description so will the use of terms that are open to different interpretations. This can be seen in the following studies that examine whether clients' expectations were met by the CHC.

In the Biswas and Sands (1984, p 42) study reported above they concluded: 'For the majority of mothers, their prior expectations were met'. The authors do not provide grounds to reach this conclusion. Clients were asked why they attended the CHC, and to give these reasons in order of importance. Expectations may not necessarily equate with reasons for attending. From the responses about satisfaction with the CHC it is not possible to infer that the prior expectations of clients were met.

A final example of problems occurring with investigating expectations occurs in Gastrell (1986). One of the author's aims was to explore 'the expectations and satisfaction of mothers attending child health centres' (Gastrell, 1986, p 73). Fifty mothers who had attended CHCs were asked what services they expected, what services they received and which service they found the most useful. The apparent implication of the study is that

satisfaction with a service may be found by observing a match between what clients expect and what they receive.

However, asking clients what they 'expect' is complex. Expectation may refer to a desire for something, to previous experience of what has been offered, or to a stereotype about what should be offered. There has to be congruence between the researcher's intentions and the participant's understanding for the participant's intent to emerge clearly. A comment by Gastrell (1986, p 77) suggests some clients may have been confused:

> *'As the survey progressed it became apparent that the principal reasons given by most mothers attending clinic coincided with their expectations. This response could have been triggered by the way the question was asked, but for the purpose of analysis the two are combined and described as "services expected".'*

There is no further information about how many people may have had responses that were triggered, why this should have occurred and what problems with reliability would result. Therefore, it is possible that clients were recounting their reason for attending CHC, rather than what they desired from the service or thought might be offered. This weakens Gastrell assertion that clients' expectations coincided with what they received.

Moreover, four expected services were *not* received by a sizeable minority of clients (see Table 3.5.1).

Table 3.5.1: Services expected but not received by all clients (Gastrell, 1986, n = 50)

Service	Number who expected services	Number who expected *and* received services	Number who did *not* receive service (%)
routine check up of babies' developmental progress	37	27	10 (27%)
advice i.e. about feeding	42	23	19 (45%)
advice about a particular problem - sleeping, teething etc.	33	24	11 (33%)
to get baby immunised	27	17	10 (37%)

(Adapted from Gastrell, 1986)

We cannot tell how clients perceive this mismatch. It could be that these services were not received because clients anticipated needing a service which they did not in fact require. Alternatively, it could suggest that people desired a service and it was not available. Given that these services described can be viewed as fairly central to the function of CHCs, this mismatch requires explanation. Unless what is meant by expectation is defined, knowing whether it is met is impossible.

Measures of satisfaction may be sought from clients regarding a number of features of the CHC. Although of some value in describing perceptions about the structure and process of the CHC they do not necessarily provide information about individual health workers. For example, Cubon (1987) reports high levels of satisfaction with CHCs by the clients in his study. He concludes this from the generally positive comments made about the value of check-ups for children and various gains that parents reported from attending CHC.

In addition, clients were asked to rate the 'atmosphere' of the CHC on five seven point semantic differential scales. These asked about friendliness, helpfulness, cheerfulness, peacefulness and efficiency. Most of these descriptors were rated very positively, the exception being peacefulness, with 30.6% rating it as neither peaceful nor noisy and 21.5% as very noisy. These scales reflect clients' general perceptions about the CHC. Since they cannot be attributed to any particular worker, they cannot be used to comment directly on the work of HVs or anyone else.

A later study which examined clients' satisfaction with CHCs also asked about different elements of the service: interpersonal manner of staff; ratings of the overall service; communication skills of staff; interest shown in client; accessibility/convenience; quality of information/advice; efficacy/outcome of care (Quine and Povey, 1993). As with the previous study it is not clear how far the client's responses refer to the work of the HV.

3.5.3 Studies that examine clients' satisfaction levels with the health visitor

The studies reported so far have problems linking together client satisfaction and the work of HVs. It has been noted that problems have arisen due to researchers attempting to infer satisfaction with the HV from *general* comments by the client regarding CHC services. This can be contrasted with studies in which the investigators have *specifically* sought

clients' reactions to the service provided by HVs as well as other features of the CHC service.

One study (Field et al., 1982) records data describing the mainly negative perceptions of 78 first time mothers. The authors conducted a survey to explore problems faced by parents in the first year of their child's life. Part of this study explored the interactions of mothers with health professionals, including HVs. Complaints were reported regarding various aspects of CHC attendance (e.g. waiting time for various CHC activities, lack of privacy, lack of information about screening tests). Health visitors are mentioned regarding two issues. First, conflicting information was given by clients' own HVs who visited them at home and the HVs seen by clients in the CHC. Second, conflicting information was given by HVs and doctors in the CHC.

A weakness in the Field et al. (1982) study is the imprecision with which the findings are reported. Expressions such as 'many', 'common', 'some', 'sometimes', 'often', 'fairly common' are used with no reference as to the number of responses behind these words. This is important because the authors suggest making changes to CHC services provision on the basis of their findings. There is clearly a difference in the implication for service delivery if five, 20 or 40 people of a sample of 78 share a particular response.

The findings of Field et al. (1982) are supported by a study (Foxman et al., 1982; Moss et al., 1986) which examined 'the transition to parenthood'. Mothers were interviewed twice ante natally, and at seven weeks, six months and 12 months post partum. The researchers examined attitudes to both home visiting by HVs and CHC visits, including attitudes about the HV. A seven point scale ranging from 'positive without qualification' to 'negative without qualification' was used. These ratings were derived from several questions which asked mothers how they felt about particular services.

The authors found that at seven weeks 49% of mothers were positive about their CHC experience; at six months this had dropped to 33%. The authors suggest the drop in satisfaction was mainly accounted for by middle class mothers whose 'positive' ratings nearly halved. The 'negative' ratings of the working class remained constant, whilst their 'positive' and 'mildly positive' ratings rose slightly. This raised the issue of why this drop

in satisfaction should occur. However, the problem is that although these ratings refer to the HV within the CHC they also refer to the CHC service as a whole. Failing to distinguish between the activity of the HV and the activity of the remainder of the CHC staff and service, makes it impossible to know the reason for the change in satisfaction, including evaluation of the impact, if any, of the HV on these changes in satisfaction levels.

A similar problem arises in Graham's study (1979) which investigated mothers' attitudes to HVs and to CHCs. This found a decrease in attendance by social class 4 and 5 mothers (who comprised 18% of the total sample), and an increase in attendance by social class 1 and 2 mothers (who comprised 39% of the total sample). Forty per cent of social class 4 and 5 and 87% of social class 1 and 2 respectively, were attending CHC five months after the birth of their child. The remaining 39% of the sample (social class 3) inexplicably are not reported by Graham. The author also reports that at five months 36% of the sample did not consider attendance at CHC important.

From the qualitative data Graham says two factors emerged. These are ambiguity about the role and responsibilities of the CHC, and experiences of personally distressing incidents at the CHC. The data suggest that mothers attend CHCs if they feel what they offer is not easily fulfilled elsewhere. Mothers tend not to visit CHCs if they see the functions as unimportant or fulfilled elsewhere.

However, Graham not only fails to distinguish between various workers in the CHCs but also merges comment on the work of the HV on home visits with CHC work. For example in describing mothers' doubts about the function of the CHC and HVs she writes (Graham, 1979, p 176):

> *'For some it was simply an uncertainty about what the clinic and the health visitor were for as these two mothers bring out:*
>
> *"She does nothing. Absolutely nothing. I don't know why she bothers coming. All she does is just sit down and say "Hello, how are you?" have a chat and that was it.'*

"All she does, she walks in she says "how are you getting on?" "Fine". "How's the baby?" "Fine" and that was it for all intents and purposes I could have been battering him and she would have never known."

These two examples refer to *home visits* and can tell us nothing about experiences in the CHC. Graham reports the perception by some clients of the policing role of the HV and the CHC. The two descriptions supplied to support this statement are again of *home visits* by HVs. A further eight interview extracts are provided which do describe CHC visits but only two refer directly to HVs. In attempting to report on attitudes to child health *services* and attitudes to HVs including their work on home visits, the power of the report to comment clearly on any aspects of services or individual workers is limited.

As stated, both Graham (1979) and Moss et al. (1986) report lower satisfaction by working class clients with CHCs. Similar low satisfaction is reported by working class mothers in McIntosh's study (1982). By contrast, Morgan et al., (1989) describing their sample by postcode, observed *no* differences between those in the best and those in the poorest housing. Moreover, Quine and Povey (1993) report that socio-economic variables were not predictive of satisfaction in their study. Therefore, the relationship between social and economic characteristics and satisfaction with CHC attendance remains ambiguous.

Sutton et al.'s (1995) well designed study avoids some of the problems of recording clients' views demonstrated by many of the previous studies. Three areas of professional consultations are explored: the client's perceptions of the professional as a listener, an explainer and a health advisor. Importantly, the client's perceptions of doctors and HVs are investigated separately.

Over half (54.3%) the clients perceived that the HV had shown a lack of attention to their concerns about their child at some time. Rather less (39.3%), had found the HV's explanations about their child's progress unclear on some occasions. Nearly a third reported never receiving health promotion and advice in their consultations. Parents were asked to record up to five aspects of services available at the CHC which they regarded as of benefit, from a predetermined list. Immunisations were most frequently mentioned

(75.9% of respondents), followed by discussion with the HV (68.1%). Health promotion advice is mentioned by only 8.3% of the parents.

Sutton et al. (1995) comment on this low figure. They argue this may reflect the low priority parents gave to this topic or lack of commitment by professionals to this aspect of child health programmes. However, there may have been confusion amongst some respondents about what constituted health promotion advice. The authors had already noted that 25 clients contacted the research team because they did not understand the term child health surveillance used in the questionnaire. If health promotion advice was not considered important, and a third of clients said they never received any health promotion and advice from HVs it raises questions about what these clients talked to the HV about and why they should consider it a benefit of attending CHC. However, as Sutton et al. note, health promotion and advice may be delivered 'disguised' in a wider discussion with the client.

Summary

Investigations into client satisfaction with HVs in the CHC have produced mixed findings. Some studies report that some mothers have a decrease in their satisfaction with CHCs over time, although it is not clear to what extent the HV is a factor in this change. Other studies have reported positive responses with regard to the HV, but the validity of these studies is marred by the following methodological problems. The design of questions used to examine satisfaction fail to do so because they are too ambiguous or too general. Low responses rates introduce problems with representativeness of the responses. The work of different staff and services is not differentiated, so that the role and effect of the HV is unclear.

Section 3. 6 Chapter discussion

This literature review has examined studies relevant to the work of the HV within the CHC. The historical context of this examination was described in terms of the origin of the CHC as an advisory centre particularly concerned with ensuring adequate nutrition for young children. The subsequent development of a programme of screening tests and immunisations as the central aspect of the service was noted. It was argued that the focus

of previous research highlighted issues to do with screening of children, with little attention given to the advisory role of the HV within the CHC.

Recent reviews of the preventive child health programme have recommended a move from the dominance of secondary prevention activities (e.g. screening tests) in favour of more emphasis on primary prevention (e.g. advice and support). The advisory role of the HV within the CHC is an example of this primary prevention. This refocus of interest away from screening, coupled with the drive towards examination of the effectiveness of services (DoH, 1997) raises questions about what is known about the advisory role of the HV within the CHC.

Studies that report clients' reasons for attending the CHC do not normally identify HVs as a reason for attendance (Steiner, 1977; Orr, 1980; Biswas and Sands, 1984; Cubon, 1987; Sefi and Macfarlane, 1985; Gastrell, 1986; Sherrat et al., 1991; McIntosh, 1992; Sharpe and Lowenthal, 1992; Sefi and Grice, 1994). The most frequent reason for attending the CHC was "to weigh the baby". The percentage of the clients who gave this as their reason is as low as 10% (Morgan et al., 1989) and a further study (Leggett, 1985) reported 44% of mothers selecting weighing. These figures were unusual, and the more common responses varied between 64% and 95% (Acheson, 1962; McIntosh, 1964; Steiner, 1977; Orr, 1980; Cubon, 1984; Biswas and Sands, 1984; Sefi and Macfarlane, 1985; Gastrell, 1986; Bolton, 1987; Sefi and Macfarlane, 1987; Sherrat et al., 1991; McIntosh, 1992; Sharpe and Lowenthal, 1992; Quine and Povey, 1993; Sefi and Grice, 1994).

Additional reasons given for visiting the CHC included: advice (Steiner, 1977; Orr, 1980; Biswas and Sands, 1984; Leggett, 1985; Sefi and Macfarlane, 1985; Gastrell, 1986; Bolton, 1987; Cubon, 1987; Sefi and Macfarlane, 1987; Sharpe and Lowenthal, 1992; Quine and Povey, 1993), reassurance (Sefi and Macfarlane, 1985; Cubon, 1987; Sefi and Macfarlane, 1987; Sherratt et al.,1991), specific services offered by some CHCs including doctor's advice, screening tests, immunisation, buying baby milk, (Steiner, 1977; Orr, 1980; Cubon, 1987; Biswas and Sands, 1984; Sefi and Macfarlane, 1985; Gastrell, 1986; Sefi and Macfarlane, 1987; Sherratt et al., 1991; Quine and Povey, 1993; Sefi and Grice, 1994).

Some study findings (Orr, 1980; Biswas and Sands, 1984; Bolton, 1984; Karmali and Madeley, 1985; Leggett, 1985; Sefi and Macfarlane, 1985; Gastrell, 1986; Cubon, 1987; Sefi and Macfarlane, 1987; Morgan et al., 1989; Sherratt et al., 1991; McIntosh, 1992; Sharpe and Lowenthal, 1992; Quine and Povey, 1993; Sefi and Grice, 1994) have also suggested a social element to attending the CHC. In terms of a *general* picture of the consumer's use of the CHC, these descriptions are informative. However, if we are interested in examining the contribution of the work of the *health visitor* in the CHC then these studies are less helpful as it is not clear to what extent if any, an HV is involved in any of these activities.

Generally, the percentage of samples who give seeing the HV as a reason for attending the CHC is always lower than the percentage who give weighing as a reason (Orr, 1980; Biswas and Sands, 1984; Leggett, 1985; Sefi and Macfarlane, 1985; Sefi and Macfarlane, 1987; Sherratt et al., 1991; Sharpe and Lowenthal, 1992; Quine and Povey, 1993; Sefi and Grice, 1994). In one CHC, as few as 16% of clients reported the HV as a reason for attending (Bolton, 1985). Biswas and Sands (1984) report that 15% of clients gave 'to see the health visitor' as their *second* most important reason for attending the CHC. Other studies have reported figures between 39.7% and 53% (Orr, 1980; Leggett 1985; Sherrat et al., 1991; Sharpe and Lowenthal, 1992; Quine and Povey, 1993). In these studies, seeing the HV at CHCs appeared to be less important to most clients than weighing their baby.

However, the contribution of the HV may be hidden by the construction of the response categories. In several studies clients say that they are attending for advice, but it is not clear from whom they are seeking or obtaining advice (Steiner, 1977; Biswas and Sands, 1984; Sefi and Macfarlane, 1985; Cubon, 1987; Sefi and Macfarlane, 1987; Quine and Povey, 1993). The same is true for response categories such as reassurance or checking progress (Sefi and Macfarlane, 1985; Cubon, 1987; Sefi and Macfarlane, 1987; Sherratt et al., 1991).

Several studies have investigated clients' satisfaction with CHC services (Biswas and Sands, 1984; Bolton, 1984; Gastrell, 1986; Leggett, 1985; Sharpe and Loewenthal, 1992; Quine and Povey, 1993). Further studies exploring consumer attitudes to services have included satisfaction with CHCs (Orr, 1980; Field et al., 1982; Foxman et al., 1982; Sefi

and Macfarlane, 1985; Moss et al., 1986; Dworkin et al., 1990; Sherratt et al., 1991). In terms of evaluating the work of the HV, two problems emerge. First, failure to define and clarify the concept of 'satisfaction' within the studies limits understanding of what the client may be describing or what the investigator was seeking to discover. Second, work of the HV is seldom differentiated from that of other workers in the CHC. Consequently, in these instances satisfaction ratings cannot be linked specifically with the HV.

Sefi and Macfarlane (1985) reported 48% of their sample described advice from the HV as a perceived benefit of attending CHC. Similarly, Sefi and Grice (1994) found 62% of participants described HV advice as a benefit. However, other studies have suggested an important level of *dissatisfaction* with the work of the HV (Field et al., 1982; Moss et al., 1986). This dissatisfaction has also been reported to increase over time (Moss et al., 1986).

In summary, previous studies present conflicting reports about the client's perception of the HV as a source of advice in the CHC. It is not clear if exchanges between client and HV constitute social chat or if clients regard the HV as a source of expertise. Few details are available of any advice or information that was given by HVs. Furthermore, no studies have been identified that examine the outcome of any advice or information given by HVs in the CHC. Therefore, there is a need to investigate both the relevance and the use of any advice/information given by the HV to the client. Accordingly, the investigation of the CHC in this thesis focuses *solely* on the advisory work of the HV. The investigation examines the content of conversation between client and HV, the use made by the client of such advice/information and the satisfaction of the client with the advice/information given by the HV.

CHAPTER 4

METHOD

Section 4.1 Introduction

This study describes clients' perspectives of the impact of two core health visiting activities, CHCs and home visits. The aims of the study were:

- identify clients' recall of issues discussed
- examine clients' reports of advice/information from health visitors
- examine clients' reports of use of this advice/information
- describe clients' accounts of the value of this advice/information

As support had been identified by some clients in previous studies (of home visits) an additional aim was included in the home visit section of the study to:

- identify the meaning of support to clients

This Chapter discusses theoretical issues that arose from the design of the study and describes methods by which the study was carried out.

Previous health visiting and client satisfaction surveys (e.g. Marris, 1971; Clark, 1973; Moss et al., 1986; Cowpe et al., 1994) provided details of the *content* and *process* of home visits and CHC visits. This study builds on this work by examining self-reports of clients of *outcomes* of such content in terms of recall, and use of advice/information by clients. Consequently, for this aspect of the study it seemed appropriate to follow a quantitative approach. This allowed statistical exploration of relationships between variables.

However, recall does not provide information about the relevance or otherwise of advice/information received. It was recognised that client reports were an important element in examining *how*, discussion with the HV impacted on the client. Further, investigation of the meaning of support for the client made it necessary to ask the mother to define and explain what that concept meant to her. These issues appeared better fitted to

a qualitative approach which would facilitate descriptions from the participants' perspectives.

Survey research encompasses different methodological approaches and has been utilised within quantitative, qualitative and mixed method studies (Bryman, 1984; Bryman, 1988; Polit and Hungler, 1999). However, the appropriateness of mixing quantitative and qualitative approaches has been questioned (Leininger, 1992). This issue is discussed in the following section.

Section 4.2 Methodological issues - paradigms

The notion of research paradigms is described by Kuhn (Pratt, 1978) who reasons that scientists work within a paradigm or theoretical framework. This framework is governed by current theories and facts that are part of that framework. This theoretical perspective shapes the individual's understanding of new information. Kuhn argues that there are no neutral facts and that truth is relative to any particular paradigm. Consequently, it is argued it is not possible to compare theoretical frameworks because they are based on different premises (Pratt, 1978).

Qualitative and quantitative research have traditionally been associated with different paradigms (Hasse and Myers, 1988; Gantley, 1994). This difference is exemplified in different philosophies of what constitutes knowledge and which are the most appropriate research methods (Bryman, 1984). Burns and Grove (1993) describe these differences (see Figure 4.2.1).

Figure 4.2.1: Differences between quantitative and qualitative research

Quantitative research	Qualitative research
hard science	soft science
focus: concise and narrow	focus: complex and broad
reductionist	holistic
objective	subjective
reasoning: logistic, deductive	reasoning: dialectic, inductive
knowledge base: cause and effect relationships, test theory, control, instruments	knowledge base: meaning discovery, develops theory, shared interpretation, communication and observation
analysis: numbers, statistical analysis, generalisation	analysis: words, individual interpretation, uniqueness

Adapted from Burns and Grove (1993, p 27)

4.2.1 Mixed methods

Tension between the two positions exists within nursing research as well as the wider academic field. Hardey (1994, p 61) comments:

> *'Qualitative research has been described by its detractors as "unscientific, subjective, of limited generality and soft". Members of the other research camp have typified quantitative research as "superficial, estranged from reality, subject to arid empiricism and hard".'*

Triangulation has been suggested by some writers (e.g.: Jick, 1979; Mitchell, 1986; Haase and Myers, 1988; Cowman, 1993) as a means of bridging the gap between the two camps. Mitchell (1986) (drawing on the work of Denzin, 1970) describes four types of triangulation (see Figure 4.2.2).

Figure 4.2.2: Mitchell's (1986) description of four types of triangulation

Type of triangulation	Meaning
data	multiple sources of data within the same study all investigating the same phenomena
investigator	more than one investigator involved in the study
theoretical	multiple perspectives and hypotheses included in the same study
methodological	within - method: several forms of the *same* data collection method within one study across - method: dissimilar but complementary methods of data collection within the same study

However, Clark (1995) suggests that mixing methodologies can result in a confused picture, with precision sacrificed due to inadequate analysis. Gantley (1994, p 31) argues quantitative and qualitative techniques *cannot* be viewed simply as alternative methods but are integral to alternative research paradigms. Similarly, Leininger (1992) supports the idea of mixing methods *within* a paradigm but suggests that triangulation across methodologies violates the integrity of both paradigms. Sandelowski (1995, p 569) describes triangulation as:

> *'... a kind of misplaced ecumenicism aimed at reducing conflict by minimising and even trivialising differences between modes of enquiry.'*

The author argues that triangulation has become 'a technique for everything' and is full of contradictions. She dismisses the idea of validity being achieved by multiple methods by suggesting this is about seeing a particular truth on which it is possible to converge. This would involve accepting that there is only one 'truth', which, Sandelowski reasons, is not accepted by all research paradigms. Further, the idea that multiple techniques can offset the limitations of each other is flawed. What is seen as a limitation in one research method may be viewed as a strength in another. Moreover, she rejects the notion that methods may be paradigm neutral. Sandeloswski argues that the paradigm will dictate the way a method is used and the subsequent analysis of data. Sandeloswski concludes that triangulation ought to be limited to techniques *within* a paradigm.

In contrast to these commentators, Hammersley (1992) suggested the quantitative/qualitative debate obscures the complexity of the research endeavour. He writes (1992, p159):

> '''*Qualitative*'' *and* ''*quantitative*'' *are sometimes used to represent fundamentally opposed approaches to the study of the social world, one representing the true way, the other the work of the devil ... But even where the evaluative overtones are absent and the two approaches are given parity, the distinction is still misleading in my view because it obscures the breadth of issues and arguments involved in the methodology of social research.*'

He identifies seven main distinctions between quantitative and qualitative research: types of data; natural versus artificial settings; a focus on meaning rather than behaviour; adoption or rejection of natural science as a model; inductive versus a deductive approach; identification of cultural patterns against seeking scientific laws, idealism versus realism. His argument is that a *range* of possible approaches exists for all seven of these elements of the research endeavour. Packaging methods into one or other paradigm introduces artificial boundaries which negate the flexibility required by researchers when considering the most appropriate means to investigate or describe a phenomenon.

Regarding types of data, Hammersley (1992) suggests the issue is not whether language is a more appropriate medium of description than numbers, but the type of *precision* required

in describing a phenomenon. Consideration should be given to pragmatic issues such as the likely accuracy to be achieved, available resources and the aim of the study, rather than an ideological commitment to a particular paradigm.

He notes the problems raised with regard to the artificiality of quantitative research methods, such as the experiment or formal survey interviewing, for example, reliance on volunteers or attempts to control variables. By contrast, qualitative methods involve a natural setting which may be seen as more authentic in terms of peoples' experience. Additionally, the formality of structured survey interviews may be contrasted with the more natural setting of qualitative interviewing where the interviewer, arguably, has a less dominant role. However, Hammersley (1992) points out all social research is part of the social world and so the notion of one particular setting being artificial or natural is a spurious distinction. Moreover, the problem of reactivity (distortion arising from the participant's awareness of being observed) is not something that is necessarily a fatal problem for quantitative research. *All* approaches, including qualitative methods, are prone to this and other problems of the research setting being unrepresentative of the world.

A distinction is made between qualitative research that seeks to describe the participant's perspective and quantitative research that focuses on participant's behaviour. However, Hammersley (1992) argues that qualitative researchers frequently do more than report participants' responses. They also analyse those perspectives and seek to explain behaviour. Conversely, quantitative researchers also investigate attitudes, not just behaviour, which implies interest in meanings.

According to Hammersley (1992) qualitative researchers' rejection of the natural sciences as a suitable model for social research is more complex than it appears. He outlines a variety of models offering different interpretations of the methods of natural science. The first problem is identifying *which* model needs to be rejected or which elements of the different models might be seen to be generic to natural science. In the author's view (Hammersley, 1992) there are few people who would suggest that *no* aspect of the natural science method is relevant to social research. He argues for the utilisation of natural science methods where they are appropriate.

Similarly, Hammersley (1992) suggests that association of quantitative research with deduction and qualitative research with induction is an over simplification. Quantitative research such as surveys may be descriptive and not focused on hypothesis testing. All research, he argues, comprises deduction and induction. Further, the notion that verstehen (understanding) is a more valid means of knowing than observations of external behaviour is challenged. Seeking understanding of another perspective is necessarily limited by an individual's ability to eradicate their own assumptions. Moreover, the experience of a group or individual has no a priori claim to truth. Therefore, hypothesis testing is inevitable, although the extent and the nature of such testing will vary.

Different goals are often posited for qualitative and quantitative approaches, the former being concerned with identifying cultural patterns and the latter with the discovery of scientific laws. However, Hammersley (1992) points out that much survey research is concerned with description of cultural patterns while some qualitative researchers make claims to theory development.

The final issue that Hammersley (1992) discusses is whether qualitative and quantitative researchers are necessarily committed to different epistemological positions. The crucial distinction is that qualitative research is based on a belief of *multiple* realities (idealist position). Quantitative researchers believe in *a* reality (realist position). The author refutes this by providing examples of quantitative researchers who espouse an idealist position and qualitative researchers who adopt a realist stance. Hammersley argues there is no *necessary* connection between an epistemological position and method and suggests there are more possible epistemologies available to researchers than the stated dichotomies would suggest.

Constant themes throughout Hammersley's (1992) argument are the necessity to select methods that are appropriate to the study, acknowledgement that this might entail combining methods, and the redundancy of paradigms as the guide to research methods. These points are made by other writers (e.g., Bryman, 1988; Seers, 1994; Sackett and Wennberg, 1997; Bonell, 1999; Closs and Cheater, 1999). Sackett and

Wennberg observe (1997, p 1036):

> *'The question being asked determines the appropriate research architecture, strategy and tactics to be used - not tradition, authority, experts, paradigms or schools of thought.'*

Therefore, objections raised by some writers (Leininger, 1992; Gantley, 1994; Clark, 1995; Sandelowski, 1995) may not be particularly robust, when they are based on the assertion that paradigms necessarily dictate methods for a study. Other criticisms such as lack of clarity and multiple methods not compensating for flaws are more serious (Clark, 1995; Sandelowski, 1995). However, these issues concern the way methods are designed and carried out within a particular study and are not the necessary result of paradigmatic conflict.

When considering the design for the current study mixed methods were not viewed as unproblematic. However, they had the advantage of flexibility which would allow quantitative and qualitative data to be used to examine the research questions. The above overview of the arguments concerning the use of mixed methods suggests that there is sufficient academic justification for using these methods within one study. Claims have been made for increased validation of data through triangulation using mixed methods (Mitchell, 1986). This is not claimed for the current study. Mixed methods were employed to allow different types of questions to be asked and correspondingly different types of data analysis (see Figure 4.2.3).

Figure 4.2.3: Methods and methodological approaches

Study method	Quantitative approach	Qualitative approach
non-participant observation		description of discussion content
semi-structured questionnaire	closed questions	open questions
semi-structured interview schedule	closed questions	open questions
analysis	descriptive statistics statistical analysis	content analysis

Section 4.3 Access

The proposed study area contained a mixture of urban and rural settings. Discussions were held with various levels of gatekeepers who would decide whether the study would be allowed to progress (see Figure 4.3.1).

Figure 4.3.1: Gatekeepers to the study

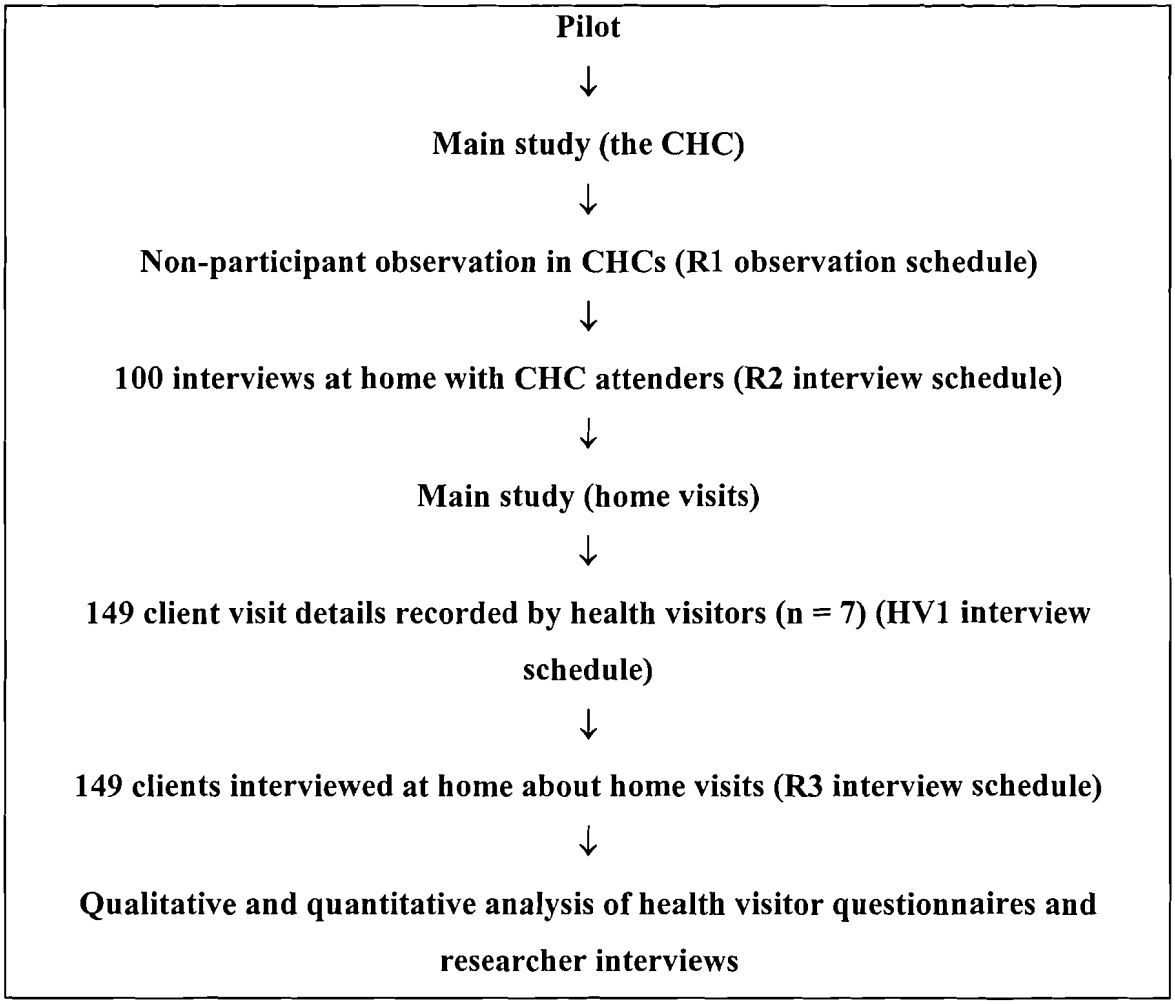
As a HV with 10 years experience, the researcher was aware of the ambivalence which research projects may encounter. A number of reasons might explain why researchers may be denied access: anxiety that the researcher might disturb the setting; perceived unsuitability of the researcher; fear of criticism; sensitivity of issues; and the anxiety of potential collaborators (Holloway and Wheeler, 1996). All these issues arose in the current study and candid discussion was necessary to satisfy individuals' concerns.

The research area covered one community Trust which consisted of seven health localities. One HV from each locality participated and a further four HVs participated in the pilot study. All HVs were volunteers.

Section 4.4. Research design

The study was descriptive, consisting of two descriptive surveys, non-participant observation and HV accounts which examined the impact of the HV in the CHC and during home visits. Figure 4.4.1 shows the plan of the study.

Figure 4.4.1: Plan of the study



Section 4.5 Samples

4.5.1 Clients - the child health clinic

Each HV had a weekly CHC, representing each locality in the Trust. Clients were enrolled in the study by the researcher at these CHCs. The sample was chosen on the basis of convenience. Convenience sampling has been described as the weakest form of sampling (Polit and Hungler, 1999), as some study participants may be different from the rest of a particular population. It is argued that if a study population is homogenous the risk of bias from convenience sampling may be reduced (Polit and Hungler, 1999).

Exclusion criteria

As the investigation was concerned with clients' views of HVs, clients attending for immunisations or medical consultations were not observed. Clients were also excluded from the study if they had been seen at a previous CHC, had already begun a conversation

with the HV or did not hold a discussion with the HV but were only told the weight of their child.

4.5.2 Clients - home visits

Selection of clients in the home visit group study was undertaken with the aims of reducing: the likelihood of HVs selecting clients; including as wide a variety of clients as possible. One or two HVs each week invited clients on selected home visits to participate in the study. Discussion with HVs established that they anticipated carrying out *at least* 12 planned home visits a week. The HVs were notified on a Thursday or Friday that it was their turn to invite clients into the study the following week. The actual number of participants was restricted to six per HV per week to enable the researcher sufficient time to interview the mothers. A maximum of six numbers randomly selected from a jar by the researcher decided which clients would be asked to participate. If a client declined to participate, the next client *not* already identified to be asked into the study was substituted. In the event of an unplanned visit, the HV was asked to toss a coin. If the coin showed tails then the visit was not included, if heads the unplanned visit substituted for the next nominated visit. Possible inclusion of unplanned visits reflected the aim of the study to include a variety of clients visited by HVs.

Recruitment was affected by unexpected HV workload demands (e.g. attendance at courses, case conferences, secondment), illness, work stress and holidays. In addition, one HV unexpectedly embarked on a round the world trip several months into the study. No other HV was able to replace her from the locality.

Section 4.6 Data collection approaches

Study data were collected through non-participant observation in the CHC, audiotaped semi-structured interviews with clients and information recorded by HVs on semi-structured questionnaires. This section provides a description of these approaches and the rationale for their use.

4.6.1 Child health clinic visit

Non-participant observation

Three of the study elements were to provide details about the advisory role of the HV in the CHC and report clients' recall of advice/information together with ratings of satisfaction. Therefore, details of the discussions were needed to ask clients about recall and satisfaction with the discussion.

Previous studies have used HVs to record details (Marris, 1976; Leggett, 1985) or taken information from CHC records (While, 1990). These alternatives were not used for three reasons. Firstly, involving HVs in the data recording during CHCs would have involved additional work for HVs. Secondly, HVs do not necessarily record *all* aspects of a discussion with the client which would have raised problems with using it as a basis to verify clients' recall. Thirdly, attempting to make appointments with clients *after* their attendance would have lengthened the process of arranging an interview. It was important to try to interview quickly, because some clients might attend the CHC weekly, risking the problem of conflation of recall over several visits (Foddy, 1996).

Two possible methods were open to the researcher in the CHC, to take notes alone or to take notes and also to audiotape the discussion. Audiotaping would have proved practically difficult. There was a considerable amount of movement by HVs around the CHC area. Therefore, it was anticipated that extraneous noise would be a problem with audiotaping. In addition, audiotaping is perhaps most helpful when the primary aim is the analysis of interpersonal processes such as Warner's (1983) investigation of interactions in the CHC. In the current study, the aim was to identify issues raised rather than examine the quality of the interaction.

Consequently, the researcher decided to observe discussions between the mother and HV and make notes of the content. There is the risk that people being observed do not behave as they would normally (Polit and Hungler, 1999). However, Foster (1996) comments that this is most likely to be a problem when participants are placed in artificial situations. In discussion with the HVs it was emphasised that the study was not concerned with commenting on their performance as individual practitioners. To try and minimise any

effect on the client and the HV the researcher adopted as discrete a position as possible avoiding the eye line between the HV and client.

It should be noted that all the CHCs observed were large rooms with a lot of activity occurring simultaneously. Therefore the effect of another person sitting taking notes was perhaps less pronounced than if the HV and client had been talking by themselves in a private setting.

Observation schedules

The main aim of this non-participant observation was to note the issues discussed between client and HV to examine the client's recall of these issues. Initially, during the pilot study, a form following Clark's (1973) schedule was utilised. However, it proved too time consuming to search for pre identified items. Consequently, a simple form (R1, appendix 1) was substituted which allowed the researcher to note issues, who initiated each issue and the total time of the discussion.

Child health clinic visit semi-structured interviews

As stated, an aim of the study was to illuminate the work of the HV by investigating clients' recall, use of and satisfaction with advice/information. Information might have been obtained from the client by self-completed postal questionnaires or by interview.

The former has the advantage of reducing researcher time and theoretically of enabling a larger number of people to be surveyed. However, a common problem is a low response rate (Polit and Hungler, 1999). Participating HVs expressed doubt over obtaining a high response rate with many of their clients. In addition, a concern in the current study was that this method might disadvantage those who were less familiar or confident with forms.

By contrast, interviews have a higher response rates than questionnaires and facilitate the exploration of issues between researcher and participant, including clarification of issues about which the participant might feel uncertain (Wilson, 1996). In addition, interpersonal skills may be used by the researcher to enhance the interview process (Burns and Grove, 1993). In order to maximise response rate and achieve the fullest account from the participant, interviews were adopted.

Two types of interview have been described: unstructured and structured (Polit and Hungler, 1999). Unstructured interviews start with a general question and thereafter the interview is flexible and led by the participant's responses. The researcher may have areas they are interested in exploring but they do not need to follow any particular sequence (Holloway and Wheeler, 1996).

Structured interviews (including semi-structured) vary in the degree of structure in types of questions and permitted interaction between researcher and participant. Open ended questions allow the participant to describe a response in their own words. Closed or fixed alternative questions offer participants a choice of responses from which to choose. Polit and Hungler (1999) suggest using a combination of questions may complement the strengths and weaknesses of both approaches.

The current study required some structure to the interview because the aim was to record the responses of a number of different people about *common* aspects of their experience of health visiting. Therefore, questions were decided prior to the interview. In order to compare responses, five point Likert scales were used when asking about elements of satisfaction (Burns and Grove, 1993). However, to facilitate understanding of the meaning behind ratings of satisfaction, follow up questions followed. These and other questions allowed the participant to express themselves in their own words.

A semi-structured interview schedule (R2, appendix 2) asked the client about aspects of their previous visit to the CHC. Questions included:

- reasons for their visit
- if the HV had given them any advice information
- importance of any discussion
- prior knowledge of issue discussed
- use by client of advice/information
- helpfulness and importance
- availability of advice/information from other sources*
- advice/information on other topics
- importance of talking with the HV at the CHC

- leaflets received from HVs*
- was the HV, their named HV*
- any general comments about service*

Demographic details were collected. The schedule comprised a mixture of open and closed questions. The closed questions required participants to choose a response from a five point Likert scale. Cue cards with the responses were given to the participants to facilitate choice (Polit and Hungler, 1999). The responses were also read out by the researcher in case participants experienced reading problems. The open questions provided an opportunity to explore with the client why they had made a particular response to a closed question. For example, clients were asked whether they knew the advice/information discussed. If they replied some or all of it the follow-up question asked how they had come to be talking with the HV about the topic.

Clients who did not recall any advice/information had a series of questions omitted but were asked the final four questions.

4.6.2 Home visits

Health visitor questionnaires

HVs were asked to record details of selected home visits on semi-structured questionnaires (HV1, appendix 3) as soon as possible after their visit. In addition to demographic information about the clients, HVs noted:

- who initiated the visits*
- specific reasons for visit*
- demographic details
- length of visit
- topics discussed
- who initiated topics
- time spent on topics*
- written information given*
- who discussion was with
- anticipated follow-up*

- whether the visits could have been carried out at HV work place*
- reason for exclusion form study (if appropriate)
- permission given for researcher to visit
- length of time since the visit to the HV completing the questionnaire.

Home visit semi-structured interviews

A semi-structured interview schedule (R3, appendix 4) asked clients about aspects of the previous home visit of the HV. This form was very similar to the previous client questionnaire (R2) but included in addition the following questions:

- the reason why the HV had visited
- whether HV had carried out any tests or examination*
- did the HV give support in any way during the visit
- could the client describe what this support meant to them
- could they have got this support from elsewhere
- was support important to them (supplemental questions about the nature of support where only asked it the client identified it as a feature of the visit)
- were they satisfied with the visit from the health visitor*
- were they usually satisfied with their visit from the health visitor*
- would they have attended the health centre or surgery for this appointment*
- any written information received*
- any general comments about health visiting *

Once again closed questions required participants to choose a response from a five point Likert scale. Cue cards with the responses were given to the participants to facilitate choice and responses read out by the researcher. The open questions provided an opportunity to explore with clients why they had made a particular response to a closed question. In addition, participants were asked about support received from the HV. This open question was accompanied by probe questions asking the participants to explore how this notion was experienced by them. For example, if the participant replied "It made me feel better" the researcher asked "can you tell me something about how it made you feel better".

Participants who did not recall any advice/information had a series of questions omitted but were asked the final seven questions.

Some questions elicited data which were more focal to the primary research questions than others. Due to time constraints, it was necessary to restrict analysis and reporting to those questions which focused most directly on the central aspects of investigation within the two studies. Similar problems have been noted by previous researchers (Warner, 1984; Clark, 1985). Questions not reported are identified above and in the appendices by an asterisk.

Section 4.7 Reliability and validity of data collection measures

4.7.1 Reliability of data collection measures

Reliability is concerned with the consistency and accuracy of measurement afforded by an instrument. Three types of reliability are described: stability, homogeneity/internal consistency and equivalence, each dimension focusing on different elements of this concept (Gibbon, 1995). Four forms (measures) were used to collect the data: CHC observation schedule (R1), HV visit questionnaire (HV1), CHC visit interview schedule (R2), home visit interview schedule (R3). The relevant aspects of reliability will be discussed in relation to each of these forms.

Equivalence

Equivalence can refer to establishing whether two allegedly similar tests do in fact measure the *same* phenomenon. This is usually a feature of studies seeking to develop new measures (Burns and Grove, 1993). Equivalence in the current study focused on inter-rater reliability and intra-rater reliability. The former is concerned with the extent to which two or more individuals agree (Fink, 1995). Thus, was there a correspondence between what was selected and how it was described (HV1) by all the HVs? The latter refers to a single individual's consistency of measurement (Fink, 1995). In the current study this referred to observations made in the CHC (R1) and the management of the interviews (R2, R3) by the researcher.

Polit and Hungler (1999) suggest that in some studies selection of data may be quite straightforward. With regard to the CHC in the current study data being recorded was not

complex but limited to topic descriptions and content (R1). Further, the researcher had the advantage of extensive clinical experience of discussions in CHCs which facilitated recording such information.

The HVs recorded a mixture of demographic information and visit content details (HV1). Demographic details were taken from their records which suggested a reasonable degree of accuracy. Other information required was structured and unambiguous; who initiated the visit, boxes to be ticked for the length of visit, whether they had given written information, who most of the discussion was with, when they would be following up the visit, whether the visit could have been carried out at their place of work, reason for exclusion from study (if appropriate).

The study HVs contributed to the development of the questionnaire (HV1) and made changes via a consensual process which might be thought to improve the inter-rater reliability.

The pre assessment data and information about issues discussed were also viewed by the HVs as neither complex nor subject to different interpretation. This is unsurprising as many details mirror the data recorded within the HV's records. Inaccuracies due to time lapses between the visits and recording of information appeared to be minimal as over three quarters (76.4%, n = 113) of the home visit questionnaires were completed by HVs within six hours of the visit.

With regard to intra-rater reliability of the interviews (R2, R3), it would not be possible to guarantee that every nuance of questioning and process would be the same between interviews. However, the researcher was aware of the importance of not leading the participant's response or suggesting that any particular perspective was more correct than any other.

Stability

The stability of a measure refers to the degree to which the measure will produce the same result on successive administrations to the *same* individual. Establishing this type of reliability may be achieved by giving the measure on one occasion followed by a future

administration of the measure to the same population two to four weeks later (test-retest reliability). The scores on the two tests can be compared by using correlational analysis. A high (.70 - .80) correlation coefficient is indicative of high reliability of the instrument (Polit and Hungler, 1999).

However, the test is of little use with measurements that might be *expected* to change between tests. The current study was examining attitudes and recall about a specific visit. Whilst attitudes might arguably be expected to be relatively stable, recall of aspects of the discussion might change over two to four weeks. In addition, there was the real risk of confusion of events, if the mother was to attend the CHC on one or more occasions or received one or more home visits before the retest (Burns and Grove, 1993).

Internal consistency (homogeneity)

Internal consistency (homogeneity) focuses on the degree to which all elements of an instrument measure the same characteristic. The items within a test are usually divided into groups according to whether they are even or odd numbers (split-half reliability). A correlational analysis is used to find the correlation coefficient. If the odd items are measuring the same attributes as the even items, the reliability coefficient should be high (Polit and Hungler, 1999, p 413). This was not appropriate for the interview schedules (R1, R2). The test is most useful when there are a large number of items that measure the same concept and whose response can be quantified (Bowling, 1994). As there were only four questions that met this latter criterion examination of internal consistency was not considered a suitable test.

4.7.2 Validity of data collection tools

In addition to reliability the validity of measures is also important. This refers to the extent to which an instrument actually measures the phenomenon being examined (Polit and Hungler, 1999). Four types of validity are commonly cited: construct, criterion, face, and content validity (Burns and Grove, 1993; Polit and Hungler, 1999).

Construct validity

Construct validity has been described as the most theoretical form of validity (Gibbon, 1995). It is predicated on the understanding that abstract concepts may be related to each

other. Statistical analysis allows investigation of any relationship between supposedly related concepts. In addition, the test can be administered to groups of individuals who are known to *differ* in the characteristic allegedly identified by the measure. These approaches can be used as means of verifying that the instrument being used, does in fact measure the intended concept. The primary use for this type of validation would be in studies seeking to measure abstract concepts, and there was no obvious means of using this approach in the current study.

Criterion validity

Criterion validity is dependent on an established measure acting as a 'gold standard' with which the new measure can be correlated (Gibbon, 1995). The absence of any such criterion measure excluded the use of this test of validity for the measures in the current study. Audiotaping of the HV's visit and comparison with an audiotape of the client's recall would have been a gold standard for recall. However, audiotaping of the HV's visit was not considered appropriate in view of the risk of influence on recall (see, p 142).

Content validity and face validity

Content validity is concerned with whether the content of the area being investigated is adequately represented within the measure. A related concept is that of face validity which asks whether the items a*ppear* to be able to measure what they intend (Bowling, 1994). Both of these types of validity essentially rely on judgement (Moser and Kalton, 1971). This is based on literature review, representatives from the relevant populations and expert panels (Burns and Grove, 1993). Both content and face validity were examined for the current study.

A literature review examining work of the HV in CHCs and during home visits formed the basis for initial drafts of the schedules and questionnaire. All documentation was sent to an expert panel comprising: six HV academics, one clinical practice teacher and one HV manager. (One panel member withdrew due to work commitments). The panel was asked to examine the measures regarding whether the questions were sufficient and appropriate for the aims of the study. Although the panel appeared satisfied that the questionnaires were fit for purpose, valuable suggestions were offered about questionnaire lay-out. The final stage of content validation was the pilot study which provided participants with an

opportunity to comment on the questionnaire. No clients offered suggestions or made negative comments. However, they may have been reticent to offer criticism to the researcher.

4.7.3 Health visitors as data recorders

Seven HVs volunteered for the main project and another four HVs for the pilot stage. Those involved in the main study represented each of seven health localities that constituted the community health Trust where the study was undertaken. Volunteers were chosen for the following reasons: they were being asked to adopt extra commitments over several months; they were the key gatekeepers to enrolling clients into the study. In addition, they were expected to allow the researcher to observe them in CHCs and provide details about their professional practice. It was therefore essential that they felt interested and not threatened by the research process.

It has been noted that who volunteers may differ from others (Sapsford and Jupp, 1996). Examination of findings from volunteer studies need to take this into account. The study HVs *may* have been particularly enthusiastic or skilled practitioners, although this study cannot demonstrate whether this was so.

The HVs recorded details of the content of their discussion with clients and this was used as the basis of investigating clients' recall of issues discussed. Alternatives would have been for the researcher to accompany the HV and record the issues discussed or for the HV to have audiotaped each discussion.

The former approach might appear a logical extension of the non-participant observation from the CHCs. However, non-participant observation is of a different order of intrusion in the private setting of the home with usually only two adults present in contrast to the public setting of the CHC where observers are a regular occurrence (Warner, 1983). Clark (1985) notes differences between the CHC visit and the home visit, one of these being the content of discussions, which can be of a more sensitive nature.

Previous researchers (Watson, 1981; Kendall, 1991; De La Cuesta, 1994) accompanied HVs on home visits but their study aims included an investigation of the process of the

visit, which arguably might necessitate observation. No particular problems were noted by the authors with this method. By contrast, Clark (1985) noted two problems with observing HVs in her pilot study. Firstly, the HVs felt 'on show'. Secondly, she posited that the nature of the interaction between the client and the HV changed significantly as a result. The seriousness of these problems led her to abandon observation in her study.

Such problems with reactivity (an observer changing the behaviour of that which is being observed) are noted in the methodological literature (Moser and Kalton, 1971; Foster, 1996; Polit and Hungler, 1999). Concealment has been suggested as a strategy to reduce reactivity (Polit and Hungler, 1999) but this solution is not practical or ethical in most health visiting research. Reactivity is thought to diminish with increased exposure to being observed. In the current study, HVs were only asked to invite clients to participate every few weeks so a practice effect would be more difficult to achieve. Moreover, clients were only interviewed once so would be unable to benefit from a practice effect.

An alternative would have been for HVs to audiotape discussions with clients. The problem of reactivity might be diminished although it would not have been possible to assess whether the HV introduced more issues, different issues or managed the discussion in a different way due to the research reminder provided by the audiotape. The notion of being reminded is particularly pertinent given that the study would have needed to be discussed in order to gain the client's consent *before* the visit began. Foster (1996) notes recording equipment including audiotaping may introduce 'serious' problems with reactivity. Therefore, it was decided that HVs would record in writing details of their discussions with clients.

It has been suggested that HVs' recording may be unreliable (Clark, 1985; Montgomery-Robinson, 1987). Specific problems included: excessive demands of recording; incorrect coding by HVs, recording content and process *simultaneously* with activity; completion of recordings long after the activity; unintentional or intentional misrecording by HVs.

The demands in the current study were simplified accordingly. Health visitors provided details of six clients or fewer per week. Details were provided in the HV's own words, avoiding coding error. Recording occurred *after* the activity. The content and process

information required was not complex and reflected normal HV activity. Health visitors recorded the number of hours between the visit and questionnaire completion. There was little motivation for intentional misrecording because HVs knew that the clients would be asked about the visit. The likelihood of unintentional error is reduced by familiarity of the issues discussed.

4.7.4 Audiotaping of interviews between the researcher and clients

The issue of whether to audiotape arose again in considering approaches to interviews between researcher and client. Certain aspects of the interview schedule, such as demographic details and questions with forced response answers, presented few problems with accuracy.

However, an important element of the study was investigating meaning for the client regarding aspects of their discussion with the HV. This was particularly the case when exploring the meaning of support which included rich description by some participants. Such responses might be more difficult to record verbatim without recording. Polit and Hungler (1999) recommend audiotaping in such circumstances. A concern was that clients would feel inhibited by the audiotaping process and a total of 10 mothers from both studies did decline to be audiotaped.

Section 4.8 Recall

Participants were asked to recall advice/information which they had discussed with the HV during the CHC or home visit. There are several competing theoretical explanations for the process of memory (Banyard and Hayes, 1994). A central feature of these theories is the proposition that people fail to recall items of knowledge and experience.

The majority of research regarding recall of advice/information within primary care is focused on doctors' discussions with their patients. A review of investigations of general practitioner consultations records varying rates of patient recall (Ley, 1993) (see Table 4.8.1).

Table 4.8.1: Comparison of studies investigating patient recall in General Practice

Study	mean number of statements	delay before recall	mean % recalled
Ley et al., 1973a	7.2	< 5 minutes	50% (n = 20)
Ley et al., 1976	5.1	1-2 weeks	56% (n = 156)
Bertakis, 1977	13.4	nil	62% (n = 50)

(adapted from Ley, 1993, p 33)

Comparisons of findings between studies in a variety of medical and experimental setting are problematic due to the difference in consultation sites, delay between the event and questions regarding recall, and method employed. However, Ley (1993) notes an inverse relationship between amount of information received and proportion of information recalled by an individual. Similarly, Anderson (1979) reports the proportion of information recalled by patients in his study decreased with the amount of information given.

Anxiety is also correlated with recall (Ley, 1993). High patient anxiety is associated with higher recall and low anxiety is associated with patients' poorer recall. Patients also appear to remember best what they are told first, and what they consider most important (Ley, 1973b). Ley suggests a variety of strategies for improving recall: discussing the most important issues first, stressing the importance of topic, using simple language, explicit categorisation of information and specific rather than general statements (Ley, 1979). Further, the author suggests that increased recall and understanding by patients leads to increased patient satisfaction.

Ley disputes that time *between* the consultation and the testing of recall has any impact on recall. However, evidence indicating that recall *is* affected by time is provided by other researchers (Foddy, 1996). This review of experimental and empirical literature argues that if memory for an event is defined as important by an individual it may be recalled fairly well for up to a year. However, events considered less important may only be recalled as well up to a month. In addition, problems with recall increase when asking participants about one of several similar types of events. Research findings recommend that the most reliable approach in this situation is to examine the *last* occurrence of the event (Foddy, 1996). Consequently, the current study focused on the last visit to the CHC by the mother and the last home visit by the HV.

Failure to recall events is an established phenomenon. It is uncertain how far investigations within medical settings can be generalised to health visiting although it has been suggested that inferences *can* be drawn (Cameron, 1994). In order to reduce the possibility of conflation of memories of different visits and maximise the recall of events (that may have had low salience for some mothers) it was planned for the researcher to interview the participants between one week and three weeks after the CHC or home visit.

Section 4.9 Ethical considerations

Before commencement of the study, ethical approval was obtained from the Local Research Ethics Committee. Fundamental to any research process is the requirement that participating individuals are not harmed (Sapsford and Abbott, 1996). A major safeguard is the notion of informed consent (Field and Morse, 1990), defined as follows (Polit and Hungler, 1999, p 141):

> *'Informed consent means that participants have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice, enabling them to consent to or decline participation in the research voluntarily.'*

4.9.1 Informed consent - the child health clinic visit

Brief details of the study were contained in an information sheet (C1, appendix 5) given to the mother when she registered with the clerical worker at the CHC. Verbal permission for the researcher to observe was obtained from clients prior to their discussion with the HV. Following this discussion, clients were approached by the researcher, informed about the study and asked if they would like to be involved. The information sheet regarding the study stressed that the client was free to withdraw from the study at any point. The researcher's name and telephone number were on the information sheet so that they could contact the researcher with any concerns. A written consent form was signed (C2, appendix 6).

On arrival at the client's home the researcher established that the client understood the study and still wished to participate. Written permission was sought for audiotaping (C4, appendix 8) and an assurance given that the audiotape would only be available to

appropriate research personnel. At the end of the interview, clients were asked whether they wished to wanted a summary of the study results, two participants asked for a copy.

4.9.2 *Informed consent - the home visit*

At the end of pre-selected visits (see Section 4.6), HVs explained the study and asked clients if they wished to participate. A consent form was signed allowing the researcher to visit (C3, appendix 7). A compliment slip with the researcher's name and telephone number was left in case clients wished to withdraw or wanted more information. On arrival at the house, the researcher verified that they understood the study and still wished to participate. Permission was gained for audiotaping as in the CHC visit study. At the end of the interview, clients were asked whether they wished a summary of the study results, 21 participants asked for a copy.

4.9.3 The role of the researcher

Other ethical concerns may arise from tensions between the role of researcher and professional responsibilities. Two issues were raised by the HVs prior to commencement of the study. How would the researcher respond to evidence of bad practice or non-accidental injury? My response to both these issues was that if an individual was at risk, I would have to intervene, the nature of the intervention depending on the situation. Neither of these issues occurred in the study.

On two occasions, clients made complaints about structure of the CHC service (the availability of milk sales). It was clear they thought that I would be able to effect some change. In order not to mislead them, I explained that the research would not highlight these concerns unless they were mentioned by many people. I also gave details of the appropriate person to contact at the health centre with whom to discuss this issue.

A further two clients having established that I was a HV, asked my advice regarding issues to do with child care. In order not to compromise the confidence of the client in their own HV *and* the trust of participating clinical staff, I referred them to their own HV.

Section 4.10 Pilot study

Following agreement from the HVs and ethical approval the pilot study was carried out with four HVs. This provided an opportunity to review practical issues, test the questionnaires and an opportunity to refine procedures if necessary (Burns and Groves, 1993; Polit and Hungler, 1999).

4.10.1 The child health clinic

Each CHC was visited before the pilot study in order to meet clinic staff, alleviate any concerns of HVs and explore the practicalities of talking to clients and observing discussions between HVs and clients. This was essential preliminary work as the process of the CHC differed markedly between the two sites involved.

At the beginning of data collection, two main problems of enrolling clients emerged. One site had a local GP present who many clients consulted for developmental assessments, immunisations *and* for illness advice (and prescriptions). As the medical consultations might have presented problems with recall of the discussion with the HV, these clients were deemed unsuitable for the study. At the second site a clinical medical officer attended bi-monthly. Therefore, observation visits were arranged on the weeks that only the HV and clerical staff were present.

Clients were asked for verbal permission for the researcher to observe the discussion between themselves and the HV. During the observation process between client and HV the researcher sought an unobtrusive position behind or to the side of the HV out of eye line of the participants. The observation schedule was simplified by removing the pre-selected items as it was found easier to note the issue than search on the schedule for the appropriate description. As a result of the pilot it appeared feasible to include timing of the total length of discussion between HV and client. This was done to facilitate comparison with previous study findings regarding length of CHC discussions. Following the discussion, the researcher explained the study to the client and invited her to participate. Other potential participants were lost during these conversations as the HVs continued to see other clients.

Nineteen clients were followed up at home. Interviews were affected at times by interruptions from children, animals and televisions. Participants were asked about the comprehensibility of the questions and no problems were described. Initially, it was not planned to audiotape the interviews. However, writing out the responses of the clients was difficult without unduly delaying the process. Therefore, it was decided to audiotape interviews in the main study.

4.10.2 Home visit

Two HVs were asked to invite clients to participate in the study. Twenty participants were interviewed by the researcher at home. The HVs did not have any apparent problems with the process of asking the client for permission, explaining the study or arranging a time for the researcher to visit.

They suggested that a reminder sheet for HVs might be useful regarding how to seek consent. This was produced with help from the HVs and used in the main study. Additionally, minor alterations to the forms were made clarifying questions regarding demographic and visit information on the HV questionnaire and increasing space for answers on the HV questionnaire and researcher's interview schedules.

Interviews about home visits required the same flexible approach as similar distractions to those experienced during follow-up to CHC visits were noted. Following the interview participants were asked about the comprehensibility of the interview schedule and no problems were reported.

4.10.3 Findings from the pilot study

The central aim of the pilot study was to explore the feasibility of the HVs coping with additional demands, recruitment of clients and the adequacy of the measurement tools and method. Inspection of the data showed that the type of information sought in the study was provided by using the different data collection tools.

Meetings were held between HVs in the pilot study and in the main study to share the pilot experience.

Section 4. 11 Main study

The seven HVs who participated in the main study worked full-time. The mean age was 41.3 years with a range of 26 years to 51 years. The mean number of years qualified as an HV was 5.6 years with a range between 1 year and 13 years. In addition to their professional qualifications 2 HVs had a degree and 1 HV a diploma. The HVs regarded their caseloads as typical of their work locality.

4.11.1 The child health clinic

The method for seeking consent, recruiting clients and observing interactions between the HV and client used in the pilot study was followed (see Sections 4.9.1, 4.10.1).

An appointment time convenient for the participant was made for the researcher to visit the participant at home. On arrival it was ascertained that the she understood the study and was still willing to be interviewed. All participants were asked for permission to audiotape the interviews.

When participants were not at home, a note was left giving another time when the researcher would return. To avoid coercion, no further attempt to interview the client was made after a second visit.

4.11.2 Home visits

A meeting with all the participating HVs was held before Christmas (1995) to review the study, share any problems and revise details for collection of the home visit data. The procedure for inviting clients to participate (see Section 4.5.2) and gaining consent (see Section 4.9.2) was carried out as described previously. Health visitors were sent questionnaires (HV1), consent forms, consent guidelines and times that the researcher was available. These forms were collected by the researcher at the end of each week or sent by the HV to the researcher.

When participants were not at home the contact procedure noted in Section 4.11.1 was again followed.

The final week of interviews occurred in the first week of August 1996. Regular contact with HVs was maintained during the data collection period. A meeting was held in July 1996 to review the study and share issues.

Section 4.12 Data analysis

Data regarding clients' CHC visits and data describing HVs home visits were analysed separately, using both quantitative and qualitative methods. For the former, a coding frame was developed, using the Statistical Package for Social Sciences (SPSS) Release 6.0 and data entered from the observation schedules, interview schedules and questionnaires (R1, R2, R3, HV1). Details of analysis are provided below. Quantitative analysis is described first and qualitative analysis second.

4.12.1 Quantitative analysis - correlational tests

The number of issues discussed by participants and HVs during CHC or home visits was recorded and compared with the number of issues the client recalled discussing. The *proportion* of issues recalled was then examined in relation to client and visit characteristics. In addition, the number of days between the HV's visit and researcher's interview were examined for correlation with recall of issues. Finally, the number of issues mentioned by the participant but not recorded by the HV and the number of hours after the visit to the HV completing the questionnaire were examined for a relationship.

Correlational tests explore whether variables are related to each other and may be parametric (Pearson's product-moment correlation coefficient (r)) or non-parametric tests (Spearman's rho(rs), Kendall's tau (tau)). Use of parametric tests is based on three assumptions: homogeneity of variance, normal distribution of data, and interval level data for both variables (Greene and D'Oliveira, 1982; Burns and Grove, 1993).

Homogeneity of variance is present when the variability of all scores is approximately the same. However, this assumption is not necessary in situations where there are the same number of subjects to each condition and this was therefore not a necessary criterion for correlational analysis (Greene and D'Oliveira, 1982).

Normality of distribution was ascertained by calculating the skewness and kurtosis of the distribution curve for all variables. Values above + 1.96 or below - 1.96 are significant at 0.05 level and indicate that the data are not normally distributed (Munro and Page, 1993).

Interval level data can be ranked *and* these ranks have a numerically equal value e.g. the baby aged four months is twice as old as the baby of two months (Bowers, 1996). This contrasts with ordinal level data which can be ranked or ordered but it is not possible to distinguish numerically between the categories. For example, a client who selects very satisfied is more satisfied than the person who selects satisfied but we cannot quantify the numerically precise value between the two selections. Details of the study variables are shown in Table 4.12.1.

Table 4.12.1: Description of variables in the child health clinic visit and home visit studies

Variables - child health clinic visit	**level of data**	**normal distribution**
Age of client	I	X
Number of children	I	X
Age of child seen at clinic	I	X
Number of issues discussed	I	X
Proportion of issues recalled	I	X
Length of discussion	I	X
Days from clinic visit to interview with researcher	I	X
Variables - home visit	**level of data**	**normal distribution**
Age of client	I	✓
Number of children	I	X
Number of issues discussed	I	X
Proportion of issues recalled	I	✓
Days from HV visit to research interview	I	X
Length of visit	O*	X
Hours from home visit to HV completing questionnaire	I	X
Issues mentioned by the client but not recorded by the HV	I	X

I = Interval level
O = ordinal level
* = Length of visit described in categories e.g. 10 -15 minutes

Child health clinic visit study and home visit study

Proportion of issues recalled in the clinic study was at interval level but not normally distributed and had many examples of tied data, therefore Kendall's tau b was selected as

the appropriate test (Bryman and Cramer, 1990) with which to examine correlation with other variables (see Table 4.12.1).

In the home study the proportion of issues recalled and the age of the client were at interval level and normally distributed therefore Pearson's product moment correlation coefficient was the test of choice (Greene and D'Oliveira, 1982). The remaining variables were not normally distributed and had many examples of tied data, therefore for correlations between these variables and proportion of issues recalled, Kendall's tau b was selected as above.

Quantitative analysis - tests for differences

A high rate of unemployed families was noted in both the clinic and the home visit study (see Tables 5.2.3, 8.2.3). Poverty is linked to a wide range of negative health outcomes (DoH, 1998c). It therefore appeared reasonable to compare recall between participants from households who had no employed member with those who had a member employed.

The samples in the clinic study and the home visit study were divided into households with at least one person who was working and households where everyone was unemployed. In the home visit the effect of membership of one or other of these two categories on recall was examined using t-test for independent groups the appropriate test for normally distributed interval level data derived from two independent groups (Greene and D'Oliveira, 1982; Polit and Hungler, 1999). In the clinic visits the proportion of topics recalled was not normally distributed, therefore a non-parametric test Mann Whitney U was used (Greene and D'Oliveira, 1982; Polit and Hungler, 1999).

In the home visit study the sample was divided into those who talked with the HVs by themselves and those who were accompanied by at least one other person. It was posited that possible distraction from the presence of people other than the client and the HV may have interfered with the client's recall. This possible effect was examined using t-test for independent groups.

One way analysis of variance (ANOVA)

In the home visit study the sample was divided into *three* groups according to the visit types (primary, issue, assessment) and examined for differences in the proportion of issues recalled between the groups. ANOVA is able to examine differences when the independent variable has more than two groups and was therefore used for this analysis (Munro and Page, 1993).

When ANOVA produces a significant result it is assumed that there is a difference between the groups and the null hypothesis can be rejected. The null hypothesis states that there is no difference between the variables being studied (Burns and Grove, 1993). At this stage it is not possible to determine between which levels of the independent variable the difference lies. Post-hoc tests introduce the risk of type 1 errors (the mistaken rejection of the null hypothesis). A number of alternative tests are available to pinpoint the source of the difference and to reduce the risk of type 1 errors. The bonferroni test is described as a frequent choice to reduce the risk of type 1 error and was selected for the current study (Burns and Grove, 1993).

Analysis of covariance (ANCOVA)

ANCOVA allows variables that might affect the differences observed between groups to be accounted for so that the groups can be examined *without* that particular variable affecting the outcome (Burns and Grove, 1993). This test was used to examine whether observed recall differences between visit type might be attributable to the different number of issues that they discussed.

4.12.2 Estimation of number of issues recalled - home visit

The 141 clients who recalled discussing issues with the HV were asked to list *all* the issues that they could remember. The issues reported by the clients for each visit were compared with the issues entered by the HV for the same visit. The proportion of issues recalled was defined as the number of issues by the client as a proportion of the number listed by the HV and worked out using the following formula:

$$\frac{\text{Number of issues recalled by client}}{\text{Number of issues listed by the HV}} \times 100 = \text{proportion of issues recalled}$$

This approach was unproblematic when the client recalled issues recorded by the health visitor. However, on some occasions (n = 43) the client described usually 1 (n = 34) topic *not* listed by the HV (see Chapter 8.4.7). This may have happened for two reasons: the client may have made an error of recall (perhaps confusing the visit with a previous one) or the HV may have forgotten to record the item.

A mismatch between the *type* of topic recalled did not necessarily affect the *number* of issues recalled by the client. For example, the HV might have recorded discussing weaning, sleep and playgroups making a total of three issues. The client might have recalled weaning, sleep and *immunisation* also recalling a total of three issues. The proportion of issues recalled by this client could be interpreted as 100% taking a purely numerical approach. However, this would obscure the mismatch between the descriptions of the issues by the HVs and by the client.

If the client had made the error, then the total of issues truly recalled from the visit would be two out of three or a proportion of 66%. If the error lay with the HV forgetting to record the topic of immunisation the client's recall was three out of four issues (proportion of recall, 75%).

The researcher had to decide which proportion to report. Participants' inclusion of issues not recorded by the HV amounted to only 5% of the total issues recorded. Moreover, it appeared likely that it would be more problematic for the participant to recall accurately than for the HVs, who usually completed their questionnaire within six hours of the visit (see Chapter 8.2.8). In addition, previous research had *also* reported patients noting items not discussed in the situation examined (Joyce et al., 1969). Therefore, the researcher chose to use HVs' reports of the issues discussed as the basis for reporting examination of the proportion of issues recalled by clients.

However, in order to explore the ramifications of this possible source of error, *both* proportions of issues recalled were calculated. This point can be clarified by reference to the example given above. In this example, the proportion of issues recalled would be calculated as either 66% or 75% according to the estimated number of issues. For all cases, both resulting proportions were entered into the parametric and non-parametric tests

used to examine proportion of issues recalled, but were not found to affect the significance levels of the results. This lack of difference may reflect the small percentage error rate noted above, and adds support for the decision to use the HVs' reports as the basis for reporting proportion of issues recalled.

4.12.3 Estimation of number of issues recalled - child health clinic visit

The 92 clients who recalled discussing issues with the HV were asked to list *all* the issues that they could remember. The issues reported by clients were compared with the issues recorded by the researcher at the CHC visit. The proportion of issues recalled was defined as above using the same formula. Participants in the CHC study recalled issues *not* recorded by the researcher on only two occasions. This discrepancy rate is far lower than that noted between client and HV in the home visits. This may have been accounted for by the fact that far fewer issues were discussed during CHC visits. The issues mentioned by the client (n = 1 for each client) but not by the researcher were not included when working out the proportion of issues recalled. The rationale for this approach is provided above.

4.12.4 Qualitative analysis

Questions in the CHC visit and home visit studies for which qualitative analyses were necessary are shown in Table 4.12.2.

Table 4.12.2: Questions requiring qualitative data analysis

Question	CHC visit study	Home visit study
why it was important to talk about the topic	✓	✓
reason for discussion with the HV given that the participant knew the advice/information	✓	✓
helpfulness and importance of the advice/information	✓	✓
importance of talking with the HV at the CHC	✓	
exploration of the meaning of support for the participant	x	✓

The researcher was aware that there were computer-assisted qualitative data analysis software (CAQDAS) packages available. With specific reference to PhD students, Webb (1999, p 327) suggests that it is preferable for the researcher to use 'manual' methods in

order to learn the process of data analysis. Webb argues that experience of analysing manually may be seen as preparation for any subsequent use of CAQDAS commenting:

> *'Qualitative data analysis is a creative endeavour involving intuition and empathy and cannot be reduced to a mechanical process. Whether CAQDAS or 'manual' approaches are used, it is the 'thinking part' of the analysis process that is paramount and this can only be done by the researcher.'*

As the researcher was not experienced in qualitative data methods it appeared prudent to adopt an approach that would focus on becoming familiar with the analytic approach rather than the associated technology. The researcher therefore decided to carry out qualitative analysis manually.

Content analysis

A variety of approaches exist for analysing qualitative data according to the intent of the study and the nature of the data (Patton, 1990). The focus of the current study's analysis was to report and compare descriptions provided by participants in response to questions asked by the researcher during one interview. Specific techniques which examine the detail of verbal *interaction* between participants such as conversation analysis or discourse analysis were unsuitable. In addition, approaches such as grounded theory which develop theory from unstructured interviews incorporating different questions were inappropriate.

Content analysis has been suggested as a means of comparing responses between different people (Polit and Hungler, 1999). Different accounts of content analysis are available (e.g. Patton, 1990; Burns and Grove, 1993) and Cavanagh (1997) observes that there are no universal rules of how to use the method. In a description of his own approach, Burnard (1991, p 461) describes the aim as:

> *'To produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system.'*

Similarly, Patton defines content analysis as:

> *'The process of identifying, coding, and categorising primary patterns in the data.'*

The specific approaches used in the CHC visit study and the home visit study are described below.

Child health clinic visit study

The questions available for analysis were noted in Table 4.12.2. Questionnaires and participants' audiotaped responses were available for 91 interviews. Another eight participants who declined to be audiotaped had their replies recorded in detailed note form by the interviewer during the interview. One interview was unsuccessfully taped, questionnaire responses were available for this participant.

Responses were organised according to the particular questions asked (see Table 4.12.2). The researcher listened to the audiotapes and transcribed the clients' responses to these questions. A full transcription of the audiotape was not carried out in the CHC study. Previous researchers have argued that transcription of entire audiotapes is not always necessary providing that essential information is transcribed (Boulton and Hammersley, 1996; Too, 1996; Hammersley and Atkinson, 1997). The researcher transcribed all responses to the open questions (see Table 4.12.2). The transcription in the current study was of content, not of process and therefore did not include features of speech such as pauses or difference in volume of speech.

Field and Morse (1990) describe the notions of latent and manifest content analysis. The former involves reviewing parts of the transcript in relation to the whole interview and discerning the purported *underlying* meaning as well as the overt meaning of participants' words. The latter, involves searching the transcript for words or phrases congruent with the research question. The authors (1990) suggest that both approaches may be used in a complementary fashion.

More recently, Sapsford (1999) suggests that coding text may be viewed in three ways. First, a representational approach which aims to reflect the surface meaning of the text as faithfully as possible. Key words used by participants may be utilised as the coding categories. This level is described as summarising the manifest content of replies. Second, adopting an 'anchoring' approach to coding involves treating all the data as linked, involving consideration of a particular response within the context of *other* responses by the participant. This might involve a degree of interpretation of the participants' responses going beyond surface reporting of occurrences. Finally, 'hypothesis testing' involves imposing category codes taken from a particular theory in order to examine the participants' responses in the light of such theory.

Burnard (1995) advises researchers to adopt a conservative view of the meanings of passages, arguing that there are not necessarily hidden meanings within texts. Therefore, in the CHC study, the decision was taken to adopt the simplest level of coding. Responses to questions were compared to identify similarities and differences between them. In addition, following the example of other studies using content analysis, the frequency of codes for each question was noted (e.g. Cole, 1988; Holcomb et al., 1993). Holsti warns against counting for its own sake but observes: (1968, preface p 2*)*:

> *'Quantification ... may yield important and interesting facts about many aspects of human experience and behaviour.'*

Moreover Holsti suggests (1968, p 11):

> *'... The content analyst should use qualitative and quantitative methods to supplement each other. It is by moving back and forth between these two approaches that the investigator is most likely to gain insight into the meaning of his data.'*

In the current study the participants' meaning was taken at face value and a description of the manifest content of each question response subsumed under a code or category which contained similar descriptions. Full description of codes and categories is given in Chapter 6.

Home visit study

The questions available for analysis were noted in Table 4.12.2. Questionnaire and participants' audio taped responses were available for 142 interviews. A further two participants who declined to be audio taped had their replies recorded in detailed note form by the interviewer during the interview. In addition, five interviews were unsuccessfully audiotaped, but questionnaire responses were available for these five participants.

In contrast to the CHC visit study, it was decided to transcribe the entire audiotape rather than essential selected segments. Clark (1985) notes the difference in the nature and content of issues discussed between CHC and home visits. This was also apparent in the current study. Description by clients of their CHC visits were generally more focused and offered simple accounts of child health and management issues frequently encountered by families.

Participants' descriptions of the last home visit from the HV were more likely to include serious, longstanding concerns. This was particularly so for those that recognised support as an element of the visit. Analysis was more likely to involve the comparison of a participant's response within the context of *other* responses and information given by the participant and full transcripts facilitated this. Audiotapes were transcribed either by a professional audio-typist or the researcher.

The transcription was of content, not of process and therefore did not include features of speech such as pauses or difference in volume of speech. All the transcriptions provided by the typist were checked against the audiotape by the researcher. This increased familiarity with the data and provided a necessary check for inaccuracies.

Responses regarding the discussion of the most important topic (see Table 4.12.2) were coded using the method described in the CHC study. That is, a description of the manifest content of each interview question was subsumed under a code or category containing similar descriptions. The frequencies of particular codes were counted. Responses to questions were compared to identify the similarities and difference between them. Many of the descriptions given by participants for particular questions could be grouped together.

Multiple reviews and sorting of the responses enabled the selection of broad categories under which to code the responses.

Analysis of the meaning of support to the participants

As noted previously the interview regarding the home visit included a question regarding whether support was received from the HV during that visit (see Table 4.12.2). The aim of the question was to explore the *meaning* for participants of support when this was identified. Eighty participants perceived support as an aspect of the visit. Forty two of these participants gave at least one other source of support (data were missing for one participant). The remaining 37 identified support as *only* available from the HV.

The aim of the current study was to identify any contribution made by the HV to the well-being of the client. Therefore, the responses of this sub-group of participants were of particular interest because participants were attributing an intervention solely to the HV. Consequently, focusing analysis on the responses of *these* clients provides information about effects of support that are most directly attributable to the *health visitor*. This does not exclude the HV as an important source of support with *other* participants. However, exploration of the relative contribution of the HV vis a vis the rest of the participants' network was beyond the scope of the current study.

The method of analysis was influenced by Burnard (1991; 1994; 1995). Transcripts and audiotapes of the 37 participants who reported the HV as the sole provider of support were identified. Transcripts were read initially in conjunction with listening to the audiotapes. Initial remarks to identify issues that reoccurred or appeared important were made in the margins of the transcripts. Analysis was a repetitive process of reading and thinking about participants' comments and trying to establish the most appropriate categories and themes within those categories. Transcripts were colour coded according to categories and themes.

Four randomly selected transcripts were coded independently by an experienced qualitative researcher. Although different expressions were used, similar concepts were identified between researcher and colleague. Burnard (1991) suggests that independent coding by another researcher helps reduce bias. Respondent validation would have been an additional means of checking the veracity of the categories although this is not unproblematic

(Sandelowski, 1986; Sandelowski, 1993). However time constraints within the study precluded this additional approach to validation.

Six categories were identified altogether and are described in Chapter 10. One category ('other people') was a response to a question from the researcher asking about alternative sources of support. The researcher was already aware from the interviewing process that there was a difference between some descriptions of support and others. This was confirmed by the process of reading and coding the transcripts. Counting of the categories and themes within those categories suggested that the initial group of 37 should be divided in two. A smaller group of 13 participants (designated Group B) and a larger group of 24 participants (designated Group C). Group B was distinguished by the apparent impact of support for the participant and by similar identification of categories by all participants in this group. By contrast, C were a less homogenous group in terms of the impact of support and the categories of support identified. Therefore, analysis of both groups continued separately.

Transcripts were divided into segments according to the category and sellotaped onto A1 unlined paper. This facilitated examination within and between categories. Constant reference was made to complete transcripts, to minimise the risk of decontextualising the transcript segments (Burnard, 1991). Categories and themes were developed for both groups and then compared with each other for differences and similarities. A full description of the categories is given in Chapter 10.

Summary

The current investigation comprises two studies which examine aspects of the HV's work in the CHC and during home visits. Seven HVs from one community Trust participated in the studies. Research aims for both studies included recall of issues discussed, clients' reports of the value of advice/information and whether they used advice/information. In addition, the meaning of support was explored with clients who had received a home visit. Data was collected by observation, semi-structured interviews with clients and recording of information by the HVs. Data analysis included descriptive statistics, inferential statistics and content analysis.

CHAPTER 5

QUANTITATIVE FINDINGS FROM THE CHILD HEALTH CLINIC VISITS

Section 5.1 Introduction

This chapter details quantitative findings from observation schedules, semi-structured interview schedules and audiotapes. A full description of the process of recording the data described, together with details of data analysis are given in Chapter 4.

As stated in Chapter 4 the objectives for the investigation of the CHC were:

- examination of clients' reports of advice/information from health visitors
- examination of clients' reports of use of this advice/information
- description of clients' accounts of value of this advice/information

This chapter is divided into four sections which cover different aspects of the quantitative findings:

- characteristics of the sample and the child health clinic visit
- researcher description of issues discussed during the child health clinic visit
- client description of issues discussed with the health visitor during the child health clinic visit
- examination of the relationship between client, visit and research variables and the recall of information

Chapter 6 describes the qualitative findings from the CHC. Chapter 7 presents a discussion of the quantitative findings from Chapter 5 together with the qualitative findings from Chapter 6.

Section 5.2 Characteristics of clients and the child health clinic visits

5.2.1 Participants interviewed (child health clinic)

Participants from a CHC in each of the seven localities comprising the study area were included in the study (see Table 5.2.1).

Table 5.2.1: Participants interviewed (child health clinic)

Locality	Number of participants
1	14
2	12
3	17
4	14
5	13
6	17
7	13
Total	**100**

Child health clinic data collection occurred between September 1995 and January 1996. Between one and two CHCs a week were observed (n = 24 CHCs). Health visitors knew at the beginning of the data collection period when the researcher would be visiting.

In two CHCs it was possible for clients to weigh their babies and leave. In the remaining CHCs if mothers wished to have their baby weighed, this necessitated some contact with the HV. Clients were asked permission for the researcher to observe their discussion with the HV. Timing began when the HV started talking with the mother. Eight discussions were unsuccessfully timed.

As the focus of the investigation was concerned with the HV, clients attending for immunisations or medical consultations were not observed. On two occasions this was not initially apparent and participants were seen by the HV and then by the practice nurse, or a doctor. The researcher followed participants during these encounters with additional staff. During the subsequent interviews at home no apparent conflation occurred between the participants' recall of their discussion with the HV and with other clinical staff.

No clients refused permission for the researcher to observe their discussion with the HV, but seven did not wish to be interviewed later. Usually they explained that they did not have time. One mother declined because she had a relative who was dying. Mothers who agreed to be interviewed were given an information sheet including a telephone contact number for more information or if they wished to withdraw.

Seventy five percent of interviews (n = 75) were carried out within one week of the CHC visit. On one occasion, a participant had had an additional CHC visit, since the visit

observed by the researcher. The mother was asked to recall the visit when the researcher had been present. The participant was able to recall the issues and there was no confusion with events from the subsequent visit. On arrival at participant's homes it was ascertained that they understood the study and a consent form was signed. All participants were asked for permission to audiotape the interviews. Eight mothers refused saying either it would make them feel nervous or they were embarrassed about their voices. Detailed notes were taken during these interviews. One further interview was only recorded for the first ten minutes due to user error. The researcher wrote notes in a field diary (usually in the car) after visits to record any unusual issues or impressions.

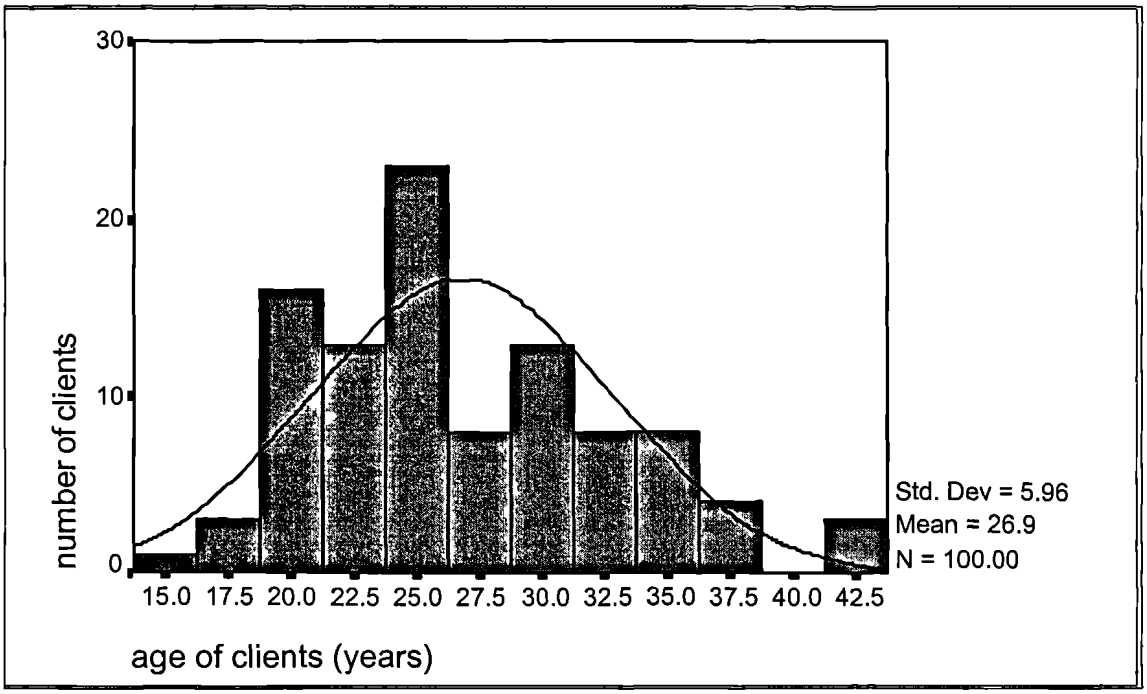
One hundred mothers were interviewed, with no access to a further 20. As demographic details of clients were collected by the researcher during interviews it is not possible to know if there were any differences between those seen and those not seen.

Clients' personal details and aspects of the CHC visits were recorded (see Figures 5.2.1 - 5.2.4 and Tables 5.2.2 - 5.2.4).

5.2.2 Age of clients

The ages of the clients are shown in Figure 5.2.1.

Figure 5.2.1: Age of clients (child health clinic)



The mean age of the clients was 26.9 years (SD 5.96), range 27 years (16 - 43 years). Examination of the histogram showed that the data were not normally distributed. Over half (56%) of the clients were between 16 and 26 years.

5.2.3 Relationship status of clients

Most of the study sample were living with another person or persons (see Table 5.2.2).

Table 5.2.2: Relationship status of client (child health clinic)

Status	Number	Percentage of total
Living with partner/relative	95	95%
Living alone	5	5%
Total	**n = 100**	**100**

Just 5% of the clients were lone parents. This is less than the local figure of 20% (Garnett et al., 2000) but nearer the national figure of 8% (ONS, 1998).

5.2.4 Employment status of households

The majority of clients (n = 71) lived in a household where one or both the couple were employed. When only one person was working this was usually full-time (n = 41) (see Table 5.2.3).

Table 5.2.3: Employment status of households (child health clinic)

Employment	Number	Percentage of total
Couples - 1 partner employed	42	42%
Couples - both partners employed	29	29%
Couples - both unemployed	24	24%
Single - unemployed	5	5%
Total	**100**	**100%**

Where both partners were working, the majority (n = 18) of mothers were employed in a part -time capacity. With one exception, their partners were working full-time. None of the single parents living alone were working.

Over a quarter (29%) of the sample were living in households that were dependent on state benefits, higher than both the local unemployment figure of 8.6% and the national figure of 4.8% (Garnett et al., 2000).

5.2.5 Number of children in the household

The number of children for each client was noted by the researcher (see Table 5.2.4).

Table 5.2.4: Number of children in household (child health clinic)

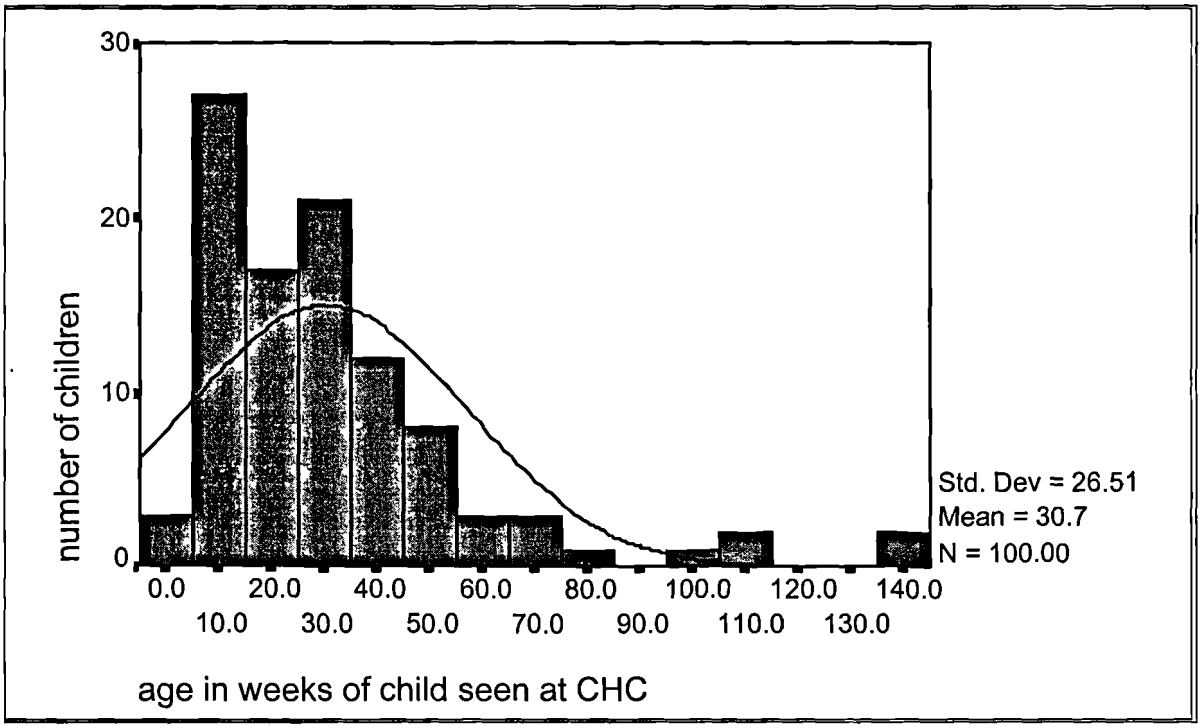
Number of children in household	Number	Percentage of Total
1	55	55%
2	27	27%
3	9	9%
4	4	4%
5	5	5%
Total households	**n = 100**	**100%**

The mean number of children per household was 1.8 (SD 1.10), range 4, (1-5). The majority of clients had only one child although a sizeable minority (18%) had 3 or more children.

5.2.6 Age of child discussed by the client and the health visitor

The age of the child who was the focus of the discussion between the HV and the client was noted (see Figure 5.2.2).

Figure 5.2.2: Age of children discussed at the child health clinic



The mean age of the child discussed at the CHC was 30.7 weeks, (SD. 26.5) range 137 weeks (3 - 140 weeks).

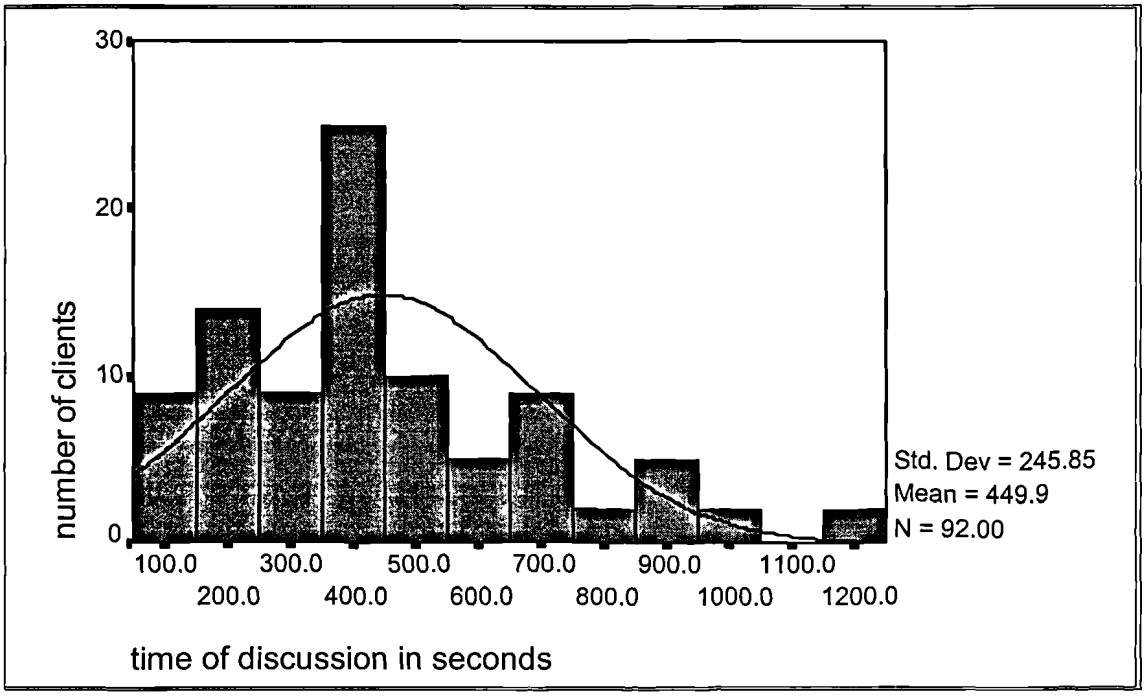
Examination of the histogram showed that the data were not normally distributed. The majority (87%) of the children discussed were under the age of one year.

Just over half (54%) of children discussed were under six months old. Thirty seven per cent were between six months and 12 months. The remainder were over one year of age. These findings are similar to previous studies (Leggett, 1985; Morgan et al., 1989).

5.2.7 Characteristics of the visit - amount of time taken in discussion with the health visitor

The amount of time spent in the discussion between the HV and the client was recorded (see Figure 5.2.3). Due to recording errors data were missing for eight cases.

Figure 5.2.3: Time taken in discussion



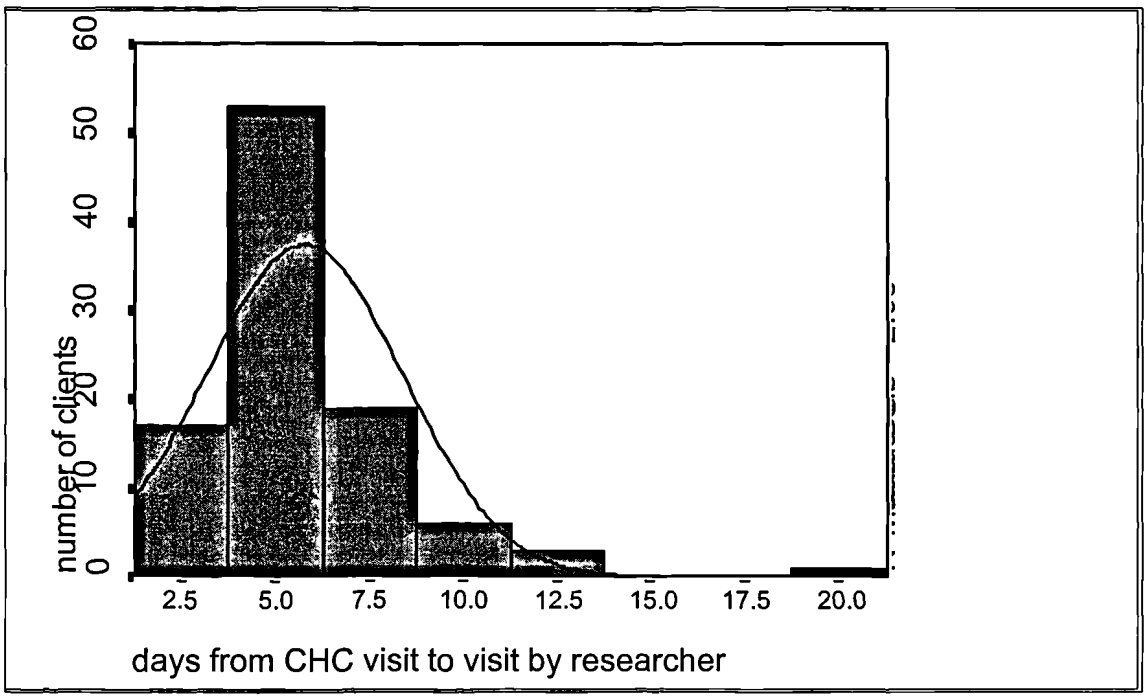
The mean amount of time for discussion was 449.9 seconds (7 minutes 49 seconds), SD 245.85, 7, range 1170.0 seconds (60-1230.0 seconds, 1 minute - 20 minutes 5 seconds). This is similar to the mean of eight minutes per discussion reported by Warner (1984).

Examination of the histogram showed that the data were not normally distributed. Two thirds (66.3%) of timed discussions took between one to eight minutes.

5.2.8 Number of days from client's visit to child health clinic to interview with researcher

The researcher calculated the number of days from the clients visit to the CHC to the subsequent interview between researcher and client, to establish whether the amount of time between the two visits affected the subsequent recall by the client (see Section 5.5). The results are shown below in Figure 5.2.4. Data was not available for one client.

Figure 5.2.4: Days from client's visit to child health clinic to interview with researcher



The mean number of days from the client's visit to the CHC to the researcher's interview was 5.77 days (SD 2.63), range 18 days (2-20 days).

Examination of the histogram shows the data were not normally distributed. Eighty five per cent of the sample were interviewed by the researcher within seven days of the CHC visit.

Summary

The mean age of clients attending the CHC was 26 years. Most clients were living either with a partner or relative. The sample showed a high rate of unemployment with 29% of the sample comprising households where no one was employed. Just over half the mothers had one child, a quarter had two children and the remaining 18% had three or more children. The mean age of the child discussed at the CHC was seven months. The mean time spent in discussion between client and HV was seven minutes forty nine seconds. The mean number of days from the client's visit to the CHC to the researcher's visit at home was 5.77 days.

Section 5.3 Description of issues discussed during the child health visit

This section describes observational data regarding the discussion between the HV and the client in the CHC. The content of each discussion, who initiated each issue within the discussion, and the time taken for each discussion, were recorded.

5.3.1 Definitions of topics and categories

The discussions consisted of 205 issues. Often, these could be grouped together under the same heading, reflecting broader topic areas. For example, clients discussed different aspects of skin problems, including nappy rash, eczema and cradlecap. These different issues were all subsumed under a *general topic* heading of 'skin problems' to facilitate organisation and analysis of the data from the 100 discussions.

The 205 issues were divided into 30 different topic areas in this way, and these were then collapsed into seven broad categories. A definition is provided for each category in Figure 5.3.1.

Figure 5.3.1: Definitions of categories (child health clinic)

Feeding
Definition: any issue concerning nutrition irrespective of the age of child includes - breastfeeding 'weaning', bottle feeding, nutrition of older children.
Management of child
Definition: behavioural issues, management of child care e.g. sterilisation of equipment, management of conditions e.g. crying, colic, includes health promotion advice, such as dental advice.
Illness/minor ailments of the child
Definition: includes advice about management of illness, progress of illness or chronic condition, assessment of child's condition.
Development of child
Definition: enquiries about development/progress of child.
Services - information about health or social provision for family
Definition: includes child health appointments, nursery details, access to GP services.
Maternal
Definition: issues of a physical or emotional or social nature.
Immunisations
Definition: advice/information about immunisation programmes and contraindications, benefits and hazards of vaccines.

5.3.2 Overview of issues raised in each category and who initiated the discussion

Table 5.3.1 shows the number of issues raised in each category and the number of occasions that issues in a particular category were raised by the HV or by the client.

Table 5.3.1: Number of issues discussed and who initiated issues discussed within each category (child health clinic)

Category	Number of issues	Initiated by hv	Percentage of total	Initiated by client	Percentage of total
Feeding	63	20	31.7%	43	68.2%
Management	42	24	57.1%	18	42.9%
Illness	39	11	28.2%	28	71.8%
Development	28	13	46.4%	15	53.6%
Services	13	7	53.8%	6	46.2%
Maternal	12	4	33.3%	8	66.7%
Immunisations	8	5	62.3%	3	37.5%
Total	**205**	**84**	41.0%	**121**	59.0%

The feeding category contained the highest number of issues discussed. Over four fifths (83.9%) of the total number of issues were accounted for by just four categories: feeding, management, illness and development. The remaining three categories: services, maternal and immunisations provided 16.1% of the total.

Over half the issues (59.0%) were raised by the client and two fifths (41.0%) by the HV. There was some variation in the proportion of issues initiated by the HV or client according to category type. Health visitors were most likely to raise issues which concerned management of the child, immunisations and services. Clients were most likely to introduce issues concerning feeding, illness, development and maternal health.

5.3.4 Description of all topics discussed and who initiated the topic

The data were organised by grouping the issues under topic headings and placing these topics in the relevant categories. In addition it was noted how many times discussion of an issue within a particular topic was raised by the HV or client.

The results are given below in Table 5.3.2 which is reported below.

Table 5.3.2: Description of all topics and who raised the topic (child health clinic)

Category - Feeding			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Diet	54	17	37
Breast feeding	9	3	6
Total number of issues	**63 (100%)**	**20 (32%)**	**43 (67%)**

Category - Management of child			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Sleep	16	7	9
Safety	13	11	2
Dental hygiene	3	2	1
Colic	3	0	3
Sibling management	2	2	0
Sterilisation of equipment	2	1	1
Behaviour	1	1	0
Footwear advice	1	0	1
Swimming advice	1	0	1
Total number of issues	**42 (100%)**	**24 (57%)**	**18 (43%)**

Category - Illness/minor ailments of the child			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Illness advice	11	5	6
Skin problems	11	2	9
Constipation	5	2	3
Vomiting	4	1	3
Thrush	3	0	3
Teething	2	1	1
Snuffles	2	0	2
Sibling health problems	1	0	1
Total number of issues	**39 (100%)**	**11 (28%)**	**28 (72%)**

Category - Development of child			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Progress of child	21	8	13
Weight development	5	3	2
Sibling development	2	2	0
Total number of issues	**28 (100%)**	**13 (46%)**	**15 (54%)**

Category – Services			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Appointment details	9	6	3
Nursery information	3	1	2
Accessing GP service	1	0	1
Total number of issues	**13 (100%)**	**7 (54%)**	**6 (46%)**

Category - Maternal			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Maternal physical health	8	2	6
Maternal mental health	2	0	2
Housing	1	1	0
Benefits	1	1	0
Total number of issues	**12 (100%)**	**4 (33%)**	**8 (67%)**

Category - Immunisations			
Topic	**Number of times recorded**	**Raised by HV**	**Raised by client**
Immunisations	8	5	3
Total number of issues	**8 (100%)**	**5 (63%)**	**3 (38%)**

Previous studies (see Chapter 3) have provided little detail of the issues about which HVs give clients advice/information. Generally, the extent of description is the provision of general headings such as "advice", "reassurance" (e.g. Cubon, 1987). The current study provides detail of the variety of topics on which HVs provide advice/information in the CHC.

Summary

A total of 205 issues were discussed between client and HV. These were divided into 30 different topic areas which were then collapsed into seven categories: feeding, management of child, development of child, illness of child, service - information about health or social provision for family, maternal and immunisations. Over half of the issues were raised by the client and two fifths of all issues were raised by the HV.

Section 5.4 Client description of issues discussed with the health visitor during the child health clinic visit

This section reports the response of the client to the discussions described above. These consumer accounts can be used to comment on the relevance and value to the client of their contact with the HV in the CHC. Participants received a semi-structured interview consisting of a series of questions, including reasons for visiting the CHC and details of any advice/information they might have received from the HV.

5.4.1 Reasons for visiting the child health clinic

The literature review demonstrates that clients often reported the most important reason for attending the CHC as being to have their child weighed (see Section 3.3). In the current study, each client was asked to give their reasons for attending the CHC in order of importance, to allow comparisons between the reasons for attending the CHC and any subsequent discussion with the HV.

In addition to the category of weight, the other reasons for attendance given by clients were subsumed under categories as previously defined (See Section 5.3) and are described in Table 5.4.1.

Table 5.4.1: Reasons given for visiting the child health clinic

Reasons for visiting the CHC	First reason	Second reason	Third reason
Weight	53	31	1
Illness & minor ailments	16	5	0
Development	13	12	0
Feeding	10	7	0
Management	3	2	0
Immunisations	2	0	0
Maternal issues	1	0	1
Miscellaneous:			
Buy baby milk	2	7	1
To change baby's nappy	0	0	1
Total	**100**	**64**	**5**

All respondents gave at least one reason for visiting the CHC. Nearly two thirds mentioned a second reason and a small minority gave a total of three reasons (n = 5).

Two descriptions were provided by mothers for attending the CHC that did not fit into existing categories. These were when the mother was attending CHC to buy baby milk (n = 8), and on one occasion when the mother used the CHC in order to change her baby's nappy.

Just over half (n = 53) of the sample gave weighing as their most important reason for attending the CHC. In addition 30 of this group said that weighing was the *only* reason they were attending the CHC. Weighing featured as the main reason for nearly half (48.8%) of the 64 clients who also gave a second reason for visiting the CHC.

The fact that nearly a third (30%) of the sample said that they were *only* attending the CHC for weighing raised questions about the relevance and the importance of the HV in the CHC. Exploration of the subsequent responses of this group of clients indicated that a client giving "weighing" as the main reason for attending the CHC, did not necessarily imply that the mother was not actually *also* intending to use the HV. This subject is explored in detail in the report of the qualitative data in chapter 6.

5.4.2 Client reports of advice/information given during the child health clinic visit

All clients were asked whether they received any advice or information from the HV, 92 (92%) responded 'yes' and eight (8%) responded 'no'.

Of 100 clients, eight could not recall receiving any information from the HV. In these CHC discussions, the researcher recorded one or two issues discussed. Comparison with a mean of two issues per client for the total sample (see Section 5.5) indicates clients with *no* recall of advice/information from the HV did not discuss more or less issues than other clients. Further analysis of those who said that they could not recall discussing anything with the HV is provided in Chapter 6.6.

Those who recalled having advice/information from the HV were asked a series of questions about the discussion with the HV. Their responses are shown in Tables 5.4.3 - 5.4.5.

5.4.3 Most important topic

The 92 clients who remembered having a discussion with the HV were asked to identify the most important issue discussed. The issues described were organised under 21 different topics. These were collapsed into the categories shown in Table 5.4.2 (see Section 5.3.1 for definitions of these categories).

Table 5.4.2: Most important topic (child health clinic)

Topic	Category	Number of times selected by client	Percentage of total**
	Feeding		
Diet		42	45.7%
Breast feeding		3	3.3%
	category total	45	**49.0%**
	Illness		
Skin problems		6	6.5%
Stools		3	3.3%
Vomiting		3	3.3%
Illness advice		2	2.2%
Snuffles		2	2.2%
Weight		1	1.1%
Thrush		1	1.1%
Sibling health problem		1	1.1%
Child health problems		1	1.1%
	category total	20	**21.7%**
	Development		
Progress		10	10.9%
Weight		3	3.3%
	category total	13	**14.1%**
	Management		
Sleep		6	6.5%
Safety		2	2.2%
Sterilisation of equipment		1	1.1%
Footwear advice		1	1.1
	category total	10	**10.9%**
	Maternal		
Maternal physical health		1	1.1%
Maternal mental health		1	1.1%
	category total	2	**2.2%**
	Services		
Appointment		1	1.1%
Accessing GP services		1	1.1%
	category total	2	**2.2%**
Total of issues		**92***	**100%**

* Data were missing for the 8 clients who said they did not discuss any issue with the HV

** = Percentage discrepancies from 100% are due to rounding of individual percentages

In 88 out of the 92 (95.7%) discussions, the participant's choice of the most important issue was concerned directly with the care or health of a child. Two (2.8%) of clients selected issues in topic ares which focused on their own well-being. The remaining two (2.8%) topics involved information about services for children or for the client. Issues in topic areas described as most important by clients covered six of the seven categories. Issues from topic areas from the category "immunisations" were not described by any clients as their most important topic.

Over two thirds (70.6%) of the issues chosen by clients concerned feeding (49.0%) or illness (21.7%). Issues concerned with management and development comprised a quarter of the most important topics selected.

5.4.4 Clients' recall of topics they discussed with the health visitor

Clients were asked to list any other issue they had discussed *in addition* to the issue which they had selected as the most important. These isues were subsumed into topics as noted previously (see Section 5.3.1). It was then possible to identify the topics that were *not* recalled by clients (see Table 5.4.3).

Table 5.4.3: Description of all topics not recalled and who raised the topic (child health clinic)

Category - Management of child		
Topic	**Raised by HV**	**Raised by client**
Sleep	1	1
Safety	7	0
Dental hygiene	0	1
Total of issues	**8**	**2**

Category - Illness/minor ailments of the child		
Topic	**Raised by HV**	**Raised by client**
Illness advice	4	1
Skin problems	1	2
Thrush	0	2
Sibling health problems	0	1
Total of issues	**5**	**6**

Category – Services		
Topic	**Raised by HV**	**Raised by client**
Appointment details	3	1
Nursery	1	2
Total of issues	**4**	**3**

Category – Immunisations		
Topic	**Raised by HV**	**Raised by client**
Immunisations	4	0
Total of issues	**4**	**0**

Category – Feeding		
Topic	**Raised by HV**	**Raised by client**
Diet	3	3
Total of issues	**3**	**3**

Category - Maternal		
Topic	**Raised by HV**	**Raised by client**
Maternal physical health	1	0
Maternal mental health	0	2
Benefits	1	0
Total of issues	**2**	**2**

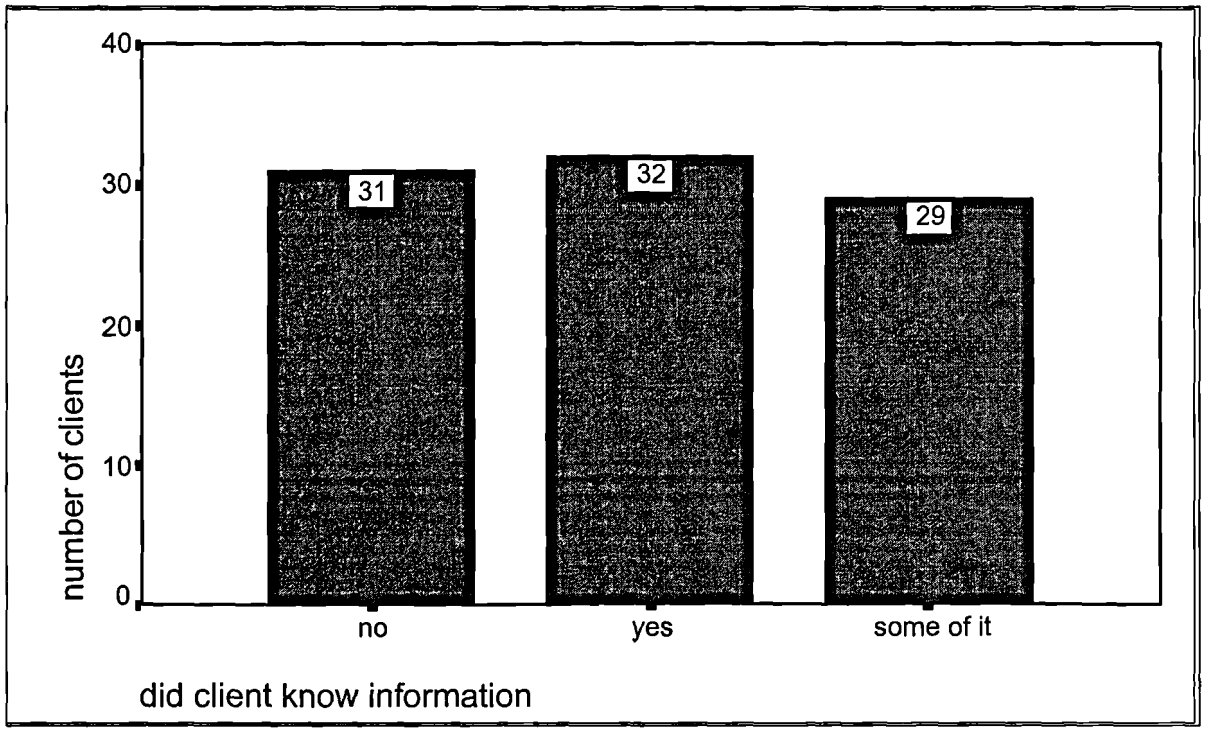
Category - Development of child		
Topic	**Raised by HV**	**Raised by client**
Progress of child	1	0
Total of issues	**1**	**0**

Twenty one percent (n = 43) of all topics discussed were not recalled by clients. Nearly two thirds (n = 27) of the topics not recalled had been raised by the HV.

5.4.5 Client reports of prior knowledge of advice/information

All 92 clients who recalled discussions were asked whether the advice/information they had received from the HV was already known to them (see Table 5.4.4).

Table 5.4.4: Clients report of prior knowledge of advice/information received



The majority (66%) of clients said that they knew some (n = 29) or all (n = 32) the advice/information received from the HV. Just over a third (n = 31) of the sample had received new advice/information.

Clients who said they knew all or some of the information were asked why they discussed the issue. This qualitative data is described in Chapter 6.

Summary

Just over half the clients reported their most important reason for visiting the CHC was to get the baby weighed. In addition, 30 of this group gave weighing as their *only* reason for attending. Ninety two per cent of the sample recalled talking with the HV. The majority of these clients (95.6%) described issues concerned with feeding, illness, development of their child and management of their child as the most important topic discussed. Just under four fifths (n = 162) of all issues discussed where raised by the clients. In terms of prior knowledge of the advice/information, two thirds of respondents stated they knew all or some of the advice/information, whilst for the remaining third the advice/information was new.

Section 5.5 Examination of the relationship between client and child health clinic visit variables on the recall of information

One objective of investigating the work of the HV in the CHC was to examine whether clients recalled discussing issues with the HV. This section of the chapter reports results of parametric and non-parametric statistical analyses carried out to explore differences and similarities between groups within the sample in terms of the proportion of issues recalled.

5.5.1 Recall of all issues

The number of issues discussed during clinic visits ranged between 1 and 5, with a mean of two issues per visit. The following variables were examined with regard to their effect on client recall of the proportion of issues discussed: number of issues discussed; age of client; number of children; age of child seen at clinic; length of discussion; days from the CHC visit to visit by the researcher, and employment status of household (see Table 5.5.1).

Table 5.5.1: Correlations with proportion of issues recalled (child health clinic)

Variable	n	Correlation coefficient (tau b)	Significance
Number of issues discussed	100	-0.2690	p = 0.002
Age of client	100	0.1255	p = 0.107 [NS]
Number of children	100	-0.0133	p = 0.878 [NS]
Age of child seen at CHC	100	-0.1037	p = 0.177 [NS]
Length of discussion	92	0.0604	p = 0.451 [NS]
Days from CHC visit to interview with researcher	99	0.1057	p = 0.195 [NS]

There was a low negative correlation between number of topics discussed and proportion of issues recalled by the client. There were no other significant correlations.

Employment of household

The sample was divided into households with at least one person employed, and households where everyone was unemployed. The effect of membership of one or other of these categories on proportion of issues recalled was examined using t-test for independent groups. There was no significant difference between the groups ($t = 1.94$, df 98, $p = 0.056$ [NS]).

Summary

There was a low negative correlation between the number of issues discussed between the HV and the client and the proportion of issues recalled by the client. No other relationship was found between selected demographic, CHC and research variables and the proportion of issues remembered.

Chapter 6 continues the CHC findings with reporting of the complementary qualitative data.

CHAPTER 6

QUALITATIVE DESCRIPTIONS GIVEN BY THE CLIENT REGARDING ASPECTS OF THEIR VISIT TO THE CHILD HEALTH CLINIC

Section 6.1 Introduction

The previous chapter described quantitative data resulting from client responses to closed questions. Chapter 6 describes qualitative data that resulted from open questions used to clarify the client's responses to these closed questions. The open questions were part of the interview schedule used by the researcher during home visits to the client. The discussions with the client were audio taped if the client gave permission. The chapter is divided into eight sections which cover different aspects of the findings:

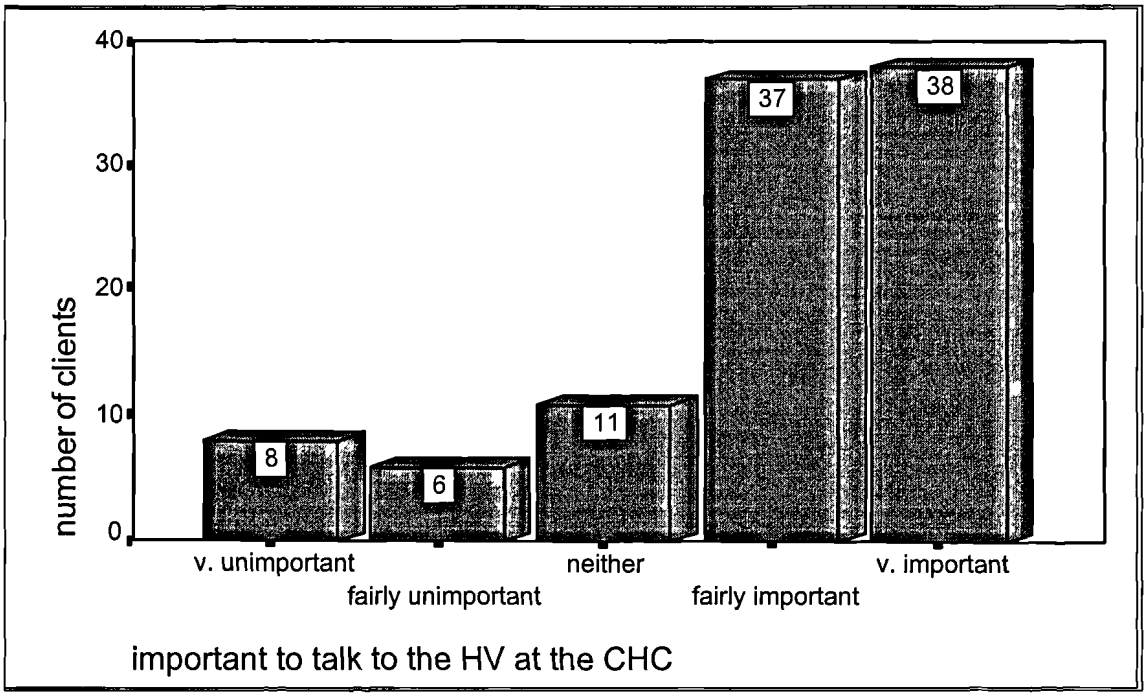
- importance to clients of talking to the health visitor in the child health clinic
- helpfulness and importance of advice/information received by the client
- reasons given by the client for discussions with the health visitor when all or some of the advice/information was previously known
- use of advice/information by the client and reasons given by clients *not* using the advice/information
- exploration of clients' accounts reporting no discussion with the health visitor
- exploration of clients' accounts who said they were attending the child health clinic visit to weigh their child *only*

Brief summaries are provided throughout the chapter.

Section 6. 2 Importance of talking to the health visitor at the child health clinic

Clients were asked to rate the importance of talking with the HV at the CHC and to describe why they chose a particular rating (see Figure 6.2.1).

Figure 6.2.1: Importance of speaking to the health visitor at the child health clinic



Seventy five (75.0%) of mothers felt it had been 'fairly' or 'very important' to talk with the HV.

6.2.1 Descriptions of the importance of talking with the health visitor

The clients' descriptions of why they thought it was either 'fairly' or 'very important' to talk to the HV was broken down into the following general categories (see Table 6.2.1).

Table 6.2.1: Reasons given for the importance of talking to health visitor

Reasons	Number
To obtain advice	34
To obtain reassurance	32
To reduce anxiety	9
Total	**75**

Obtaining Advice

The most common reasons given for why it was 'fairly' or 'very important' to speak with the HV were either wanting advice or wanting to know what to do about an issue.

(Client 30)

'For Laurie's safety and to give me some advice, you know, like with my money problems. If you can save even a couple of quid it helps.'

(Client 38)

'Just to get information to know how best to continue after her being in hospital, and still having the diarrhoea.'

(Client 62)

'I try to find out as much as possible about the baby. With my first child I didn't really think that clinics were important as they are I just took him to get weighed. I never really bothered talking to anyone because I had my mother you see. My mother isn't here now so I tend to use these places more than what I ever did, whereas last time I didn't need them.'

Obtaining Reassurance

A third of clients described the importance of talking with the HV from the perspective of the reassurance that was gained. Some mothers linked the advice/information received with reassurance. However, the distinguishing feature between clients coded as describing 'to obtain advice' and clients coded 'to obtain reassurance' is the latter group always referred to reassurance in *addition* to advice/information received.

(Client 56)

'I think you really go to make sure you know your child is doing things right, and to have a general chat with them if there is anything wrong at all. You know they are there.'

(Client 91)

'Because of the weight, it was reassurance. Had I simply been able to go in there and place Linda on the scales and weigh her myself and come away I would still have had a nagging in the back of my head, I would still have wanted someone to reassure me that everything was okay.'

(Client 95)

'Well because it was her [baby's] *first visit and I just wanted reassurance and to talk to somebody. To check that everything I was doing was right, and then she gave me some advice that I didn't know.'*

Alleviating anxiety

The final description provided by clients was that of alleviating anxiety felt by the mother (n = 9). In one instance a mother had had a concern about the baby for three months, but in most cases a recent change over the last few days had led to the mother's anxiety.

(Client 19)

'It was very important I had to ask them because it was on my mind. I had been worrying all week, I had waited until Thursday so I could go to the clinic.'

(Client 23)

'Because when my mum actually came home to me and said to me Daniel's not put weight on for three weeks, my immediate reaction was "God, they'll think I'm starving him" which I knew they wouldn't but to me just something didn't feel right. So I thought I'm going to have to go and see them because I want to know what they've got to say because there could be something wrong. It could actually be something wrong with him and I wanted to know there and then what was the matter and why.'

(Client 84)

'Because you see with him having that thingy all over his face, you worry don't you. Is he going to be all right.'

6.2.2 Clients who reported it was unimportant or neither important nor unimportant to talk with the health visitor

Most mothers felt it had been 'fairly' or 'very important' to talk with the HV. However, a quarter of the sample (see Figure 6.2.1) did *not* report it as important. Their reasons are shown in Table 6.2.2.

Table 6.2.2: Not important or neither important nor unimportant to talk with the health visitor at the child health clinic

Reason	Number
Clients just came to CHC to weigh their child	9
Client had nothing to ask the HV	8
Discussion was of a trivial nature	5
Dissatisfaction of client with quality of information	3
Total	**25**

Talking to the HV described as neither important nor unimportant

Eleven clients selected 'neither important nor unimportant' to speak with the HV and gave four different explanations.

Clients just came to weigh their child (n = 2)

(Client 78)

> *'Because all I really wanted was to see how his weight gain was going. I'd already spoken to her about his feeding habits earlier really, so I didn't think it was really necessary to see her anyway.'*

Clients had nothing to ask the HV (n = 3)

(Client 77)

> *'They are there if you want them, but I didn't have anything to discuss with them.'*

Discussion was of a trivial nature (n = 4)

(Client 9)

> *'Wouldn't have been a big deal if I hadn't been able to talk to health visitor ... the issue would have sorted itself out.'*

[taken from interview notes]

Dissatisfaction with quality of information (n = 2)

(Client 63)

> *'I listen to what they say then carry on the way we are. If I thought he was going to end up overweight then I would of like listened to her, but really when you see him with nothing on he's skinny.'*

Talking to the HV described as fairly unimportant

A further six mothers described the discussion with the HV as 'fairly unimportant', and provided three reasons for this.

Clients just came to weigh their child (n = 3)

(Client 7)

> *'Nothing has really changed in Shaun so I just literally went to get his weight and not to talk to anyone in particular.'*

Clients had nothing to ask the HV (n = 2)

(Client 98)

> *'Because I didn't have anything to ask.'*

Discussion was of a trivial nature (n =1)

(Client 96)

> *'It wasn't really important but you know, I wanted to know whilst I was there. Its just something that I remembered to ask when I was there.'*

Talking to the HV described as very unimportant

The final group of eight respondents perceived talking with the HV had been 'very unimportant' and explained this in one of three ways.

Clients just came to weigh their child (n = 4)

(Client 13)

> *'I would have been content to see the nurse, I only went for the weighing really.'*

Clients had nothing to ask the HV (n = 3)

(Client 92)

> *'Because I was not worried about anything to do with his development, his sleeping, his feeding. As far as I was concerned everything was as it should be, but the nice thing is they always do encourage you to talk about the baby they are very helpful.'*

Dissatisfaction with quality of information (n = 1)

(Client 15)

> *'Because the information that she gave was useless really. It will work for some, but not for everybody so what they have got to do is get more information that will suit everybody not just certain people.'*

Summary

Obtaining advice (45%) and reassurance (43%) were the main reasons cited for it being 'fairly' or 'very important' to speak with the HV, reducing anxiety was mentioned by a small number of participants (12%).

The 25% of participants who selected 'neither important nor unimportant', 'fairly unimportant' or 'very unimportant' ratings viewed talking with the HV as not of much consequence because: they were primarily interested in their child's weight, had nothing to ask the HV, felt the discussion was of a trivial nature or, in a few cases, were dissatisfied with the content of the advice/information.

In addition to the general question about whether it had been important to speak with the HV, each mother who recalled a discussion was asked *specifically* about the importance and helpfulness of the advice/information. These responses are reported next.

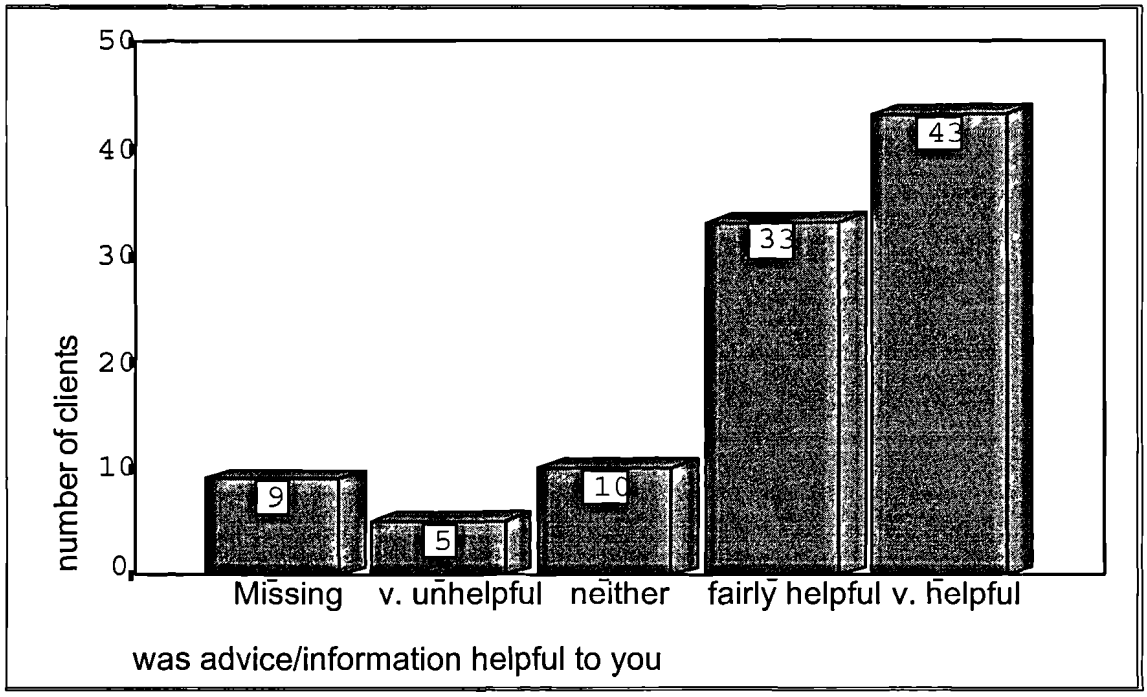
Section 6.3 The helpfulness and importance of the advice/information to the client

Clients were asked to grade whether it had been helpful and important to have the advice/information and to explain the nature of any importance or unimportance. This provided an opportunity to explore the perceived value or otherwise of these discussions.

6.3.1 Helpfulness to the client of the advice/information

Clients' responses to a five point attitude scale regarding helpfulness of the advice/information are shown in Figure 6.3.1.

Figure 6.3.1: Helpfulness of advice/information to client (child health clinic)



* = There were missing data for 9 clients including the 8 who did not recall any discussion with the HV

Descriptions of helpfulness of advice/information

The majority of clients (n = 76) viewed the advice/information as either 'very helpful' or 'fairly helpful'. Mothers were asked to comment on the helpfulness or unhelpfulness of the advice/information received in order to explore in what way they perceived such advice/information as useful or otherwise. A third (n = 32) of these responses were described as helpful by the client because of the reassurance provided.

Reassurance

Reassurance was mentioned explicitly by 15 clients, for example:

(Client 78)

> *'With being a new mum I don't really know. You can read the books but I always think it is nice to get the advice of a person themselves who has sort of been around it all the time and that is really helpful, it reassures you.'*

A further 17 mothers provided descriptions and phrases that implied reassurance such as: 'putting my mind at rest', 'peace of mind', 'knowing everything was okay':

Client 48)

'Because it was worrying me and it got rid of that worry.'

(Client 82)

'It was peace of mind to know that I was doing the right thing.'

Useful information

Just over a quarter (n = 25) of those that describing the advice/information as 'very' or 'fairly helpful' explained this as solving a problem or increasing the mother's understanding of a situation.

(Client 27)

'It was very helpful because I didn't realise about the paracetomol, and it seems to have done the job.'

(Client 31)

'The information she [HV] *gave me was new. I wanted her advice because she is experienced, rather than the grapevine advice.'*

(Client 45)

'His rash is gone so the information worked and therefore was very useful.'

Second opinion

A further 11 mothers described the helpfulness of the discussion with the HV arising from being able to get a second opinion about some aspect of their child's health or management.

(Client 34)

'Well because more to back up what the book had said plus I didn't want to make a mistake and make her more poorly than she had already been.'

(Client 36)

'Because like I say I knew he was all right but she gave me that, she sort of said "yeah he is fine, you have no problems", so I was quite happy with that.'

(Client 83)

'I knew I was doing okay, but I needed someone to confirm she was okay and I was doing all I can.'

Made me feel better

The remaining responses (n = 8) were framed in terms of the client feeling better in some way after speaking with the HV:

(Client 91)

'Being able to see the weight and have it explained and if you like being given a pat on the back and confidence, and for somebody professional to say "well done, she's thriving" .'

(Client 41)

'She made me feel better in myself. I'm not the only person who gets these things there are other people around which makes me feel better.'

(Client 7)

'It was helpful to be able to talk to somebody about it if you know what I mean. Mainly like she understands, medically she understands so instead of talking to a neighbour or something I can actually talk to somebody who can talk back because she understands the problem. I find a lot of other people I talk to seem to sort of like don't have a clue. I mention hydrocephalus and they go "what", they don't have a clue.'

Advice/information described as neither helpful nor unhelpful

Ten of the participants reported the advice/information as 'neither helpful' nor 'unhelpful'. One client was not particularly interested in the advice/information from the HV and rated it 'neither helpful nor unhelpful' because she just wanted reassurance:

(Client 97)

'Because, I just wanted reassurance.'

The remaining nine mothers were dissatisfied with the advice/information in some way. Three mothers reported that the advice/information did not resolve the problem:

(Client 10)

'Sounds like the right thing to do but it didn't work.'

A further four mothers stated that they did not agree with all the HV's advice/information:

(Client 23)

'Yes I can see what they say about me giving more food, but giving him at supper time I disagree with in that way it is unhelpful.'

The remaining two mothers described the advice/information given as limited:

(Client 20)

'Because most of what was told I already knew, so it didn't really help.'

<u>*Very unhelpful*</u>

Five clients described the advice/information received from the HV as 'very unhelpful'. Two mothers *had* to discuss the issue which had been raised by the HV:

(Client 15)

Client: *'Health visitor thinks that everyone is like a first time mother, they don't know nothing. But like when I had Sharon and like I listened to all their advice but I learned from my mistakes and now I know with her* [second child] *like what they are saying is no good to her it didn't help her at all.'*

Interviewer: *'Did it help first time round with Sharon?'*

Client: *'Yeah because I didn't know no better. I thought like with them being health visitors they know everything, which they didn't.'*

The remaining three mothers were all dissatisfied with the content of their discussion with the HV. In one case the mother also commented negatively on the attitude of the HV:

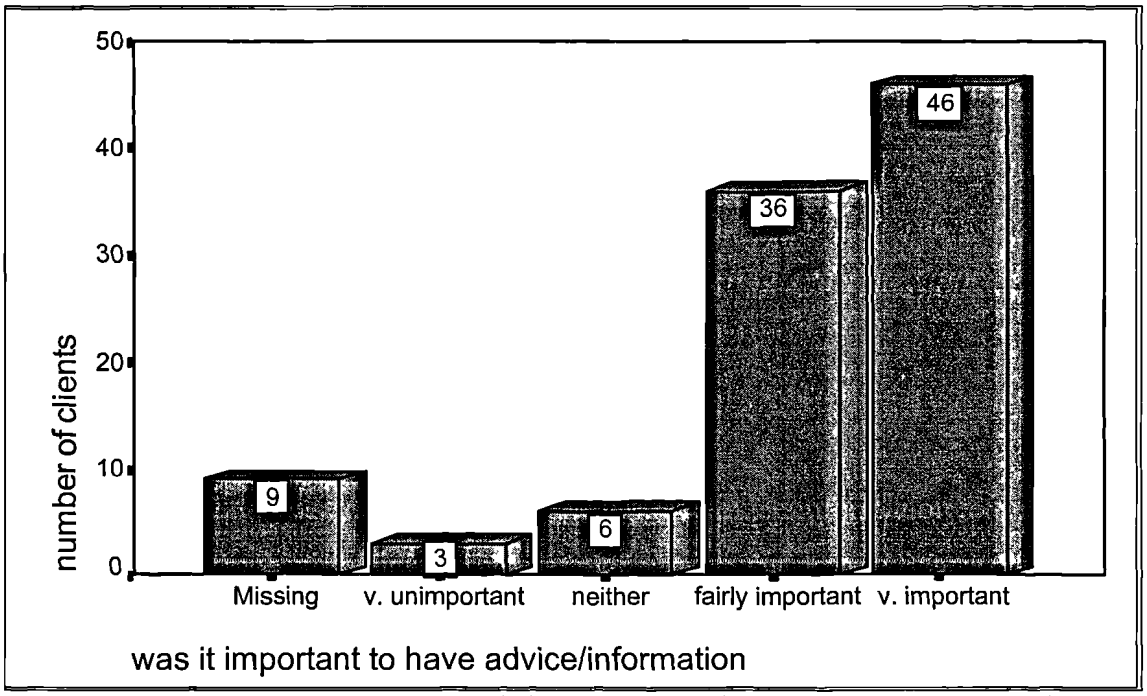
(Client 44)

> *'Because I didn't go about feeding, I went about the teeth, and they wouldn't listen, to me. Everything I said was wrong and then it was "oh, is it your first child"? Like I don't know what I'm doing, that's what its like. They just don't listen like, whatever you say is wrong, and they know, do you know what I mean and they don't know. It's so hard to explain, its just they think they know everything and they don't.'*

6.3.2 Importance of information

The five point scale regarding the importance of the advice/information to the client sought to examine the emphasis which the mother placed on the issue (see Figure 6.3.2).

Figure 6.3.2: Importance of advice/information (child health clinic)



* = There were missing data for 9 clients including the 8 who did not recall any discussion with the HV

Descriptions of importance of advice/information

The majority (n = 82) of clients reported the advice/information as either 'very important' or 'fairly important'. The remaining nine mothers reported that the advice/information

received from the HV had either been 'very unimportant' or 'neither important nor unimportant'. Five explanations of why the advice/information was important were provided by mothers.

Reassurance

The largest group of responses (n = 27) described the advice/information as providing reassurance for the respondent. In 12 interviews reassurance was mentioned overtly by the mothers:

(Client 42)

'It gave me reassurance to know that I was doing it right.'

The remaining 15 mothers either used the expression 'doing the right thing' (n = 6) or 'setting mind at ease' (n = 3) or described wanting to use the HV to check an issue (n = 6). These phrases also encompassed the notion of being reassured by the HV that the client was caring for her baby correctly or that there was no problem with her child.

(Client 43)

'To make me feel better, it's for someone to tell me 'you're doing the right thing.'

(Client 61)

'It was double checking.'

Solved problem/improved situation

Just over a fifth (n =18) of those who viewed the advice/information as 'very' or 'fairly important' explained this importance reporting a particular concern solved or improved.

(Client 53)

'If she hadn't of told me to go [to the GP] *I would still be going next week instead of this week.'*

(Client 87)

'Because I would have just have left it waiting for it to spread seeing if it went any different, and she said if you do it with that it will save it spreading because if not it could spread on to their eyelids and just keep going. I've never had it before with any of the others so its like something new.'

(Client 41)

'Because without that information I would probably have just carried on the way I was, and I've got my little boy as well, so I've got to get over this for his sake really because its when I'm out with him that it always happens, and I'm just like worried what's going to happen to him.'

Professional information needed

Thirteen participants identified the *source* of the advice/information as the aspect of importance to them. These clients valued the HV for providing professional knowledge that was acceptable and trustworthy.

(Client 19)

'I could have found it out from another mum or I could have looked it up in a book or leaflets that I've collected, but I know if I went to the health visitor she could give me a straight answer without me having to look it up and I know it would be the exact right answer.'

(Client 31)

'Getting it [advice] *off everybody else to me is the wrong thing to do. To me, that's what they* [HVs] *are there for. They are there for that sort of thing, to ease the mum as well as for the baby. ... They are* [family] *talking from their experience of having me and my brothers. The health visitor is talking about from years of experience with all different babies.'*

(Client 86)

'Like I know what to feed her and Daniel, but she [the HV] *knows more about nutrition than I do. So if she tells me 'oh its good to give them that' I'll take her advice and I'll do it.'*

Child's well-being

Twelve mothers perceived the advice/information as concerned with improving or safeguarding their child's welfare (n = 5) or health (n = 7). There was a clear implication arising from their comments that *anything* that might maximise their child's welfare or health was intrinsically important.

(Client 14)

'It concerns my child's health, it's important to get it right.'

(Client 22)

'Because you want to do the best for baby, you want to give her a headstart in life, so that any help you can get is very important.'

(Client 23)

'Well obviously its important that my child's welfare is looked after, its important to me that everything is all right.'

Was worried about the baby

The same number (n = 12) described amelioration of worried feelings by the discussion with the HV.

(Client 47)

'It makes me feel better, it makes me feel more confident that she is okay. Nobody is worried, but it doesn't make me not worried.'

(Client 48)

'It was worrying me and it probably was affecting the way I was him, because I was constantly concerned that he was having enough and concentrating on that

rather than other things I suppose. If you are concentrating on him twenty four hours a day and you don't get other things done, it spirals, and you then get worried about other things.'

(Client 49)

'It was important for me to go, to realise that I could go there. Sometimes even the simplest thing preys on your mind and so to be honest when I got in there [health centre] *I had forgotten all about the clinic and it was a matter of clinics on today and I'm going to go and find out. And just saying that made me feel I'll get some answers, maybe they will be able to help me.'*

Advice information described as neither important nor unimportant

Six mothers reported the advice/information was 'neither important nor unimportant'. Two clients explained that they were informing the HV about their child's progress at hospital (both children had chronic health problems). These discussions were in the nature of information sharing but not identified as important.

(Client 7)

'I had discussed everything with the physio and with other people. Obviously it is important for her to know everything and be up to date, but it didn't really matter about me talking to her because, I had already discussed it with other people anyway.'

A further two mothers were seeking reassurance about an issue but were not particularly concerned.

(Client 13)

'I had already convinced myself that he was okay it was just nice to be reassured.'

The remaining two clients perceived the HV as not a particularly important source of advice/information.

(Client 38)

'You make up your own mind up anyway basically.'

Advice/information described as very unimportant

Three clients described the advice/information as very unimportant. In one instance the mother had not wanted to discuss the issue which was raised by the HV.

(Client 2)

'Not a problem.'

The remaining two mothers disagreed with the advice/information offered by the HV.

(Client 15)

'Because half of them don't have kids, so they haven't got the experience so all they deal with is ten minutes or that whatever at the clinic. All they really know is what they read in books. They are not like with kids twenty four hours a day so they don't know what the bairns are like. Can I just say something else, she was on about her sleep pattern. You can't make a little baby go to sleep if she don't want to. So, I can't like get her to sleep at 7 o' clock and tell her like she's got to sleep all the way through until seven the next morning. Its all right them saying, but it doesn't make any difference.'

(Client 51)

'It was not much help really. It would have been pointless to have come home and do that because I would have had the same problem anyway.'

Summary

A third of those who described the discussion with the HV as 'fairly' or 'very helpful' did so in terms of the reassurance gained. A quarter reported a problem solved or increased understanding of an issue. The remaining smaller group of responses was divided between checking an issue with the HV (12.1%) and mothers who felt better after speaking with the HV (8.8%).

Rating the advice/information 'neither helpful nor unhelpful' or 'very unhelpful' was generally explained by the client being dissatisfied with the content.

The largest groups of participants describing the advice/information received from the HV at the CHC as important referred to obtaining reassurance (32.9%), and problem solving (22.0%). In addition, 15.9% of this group highlighted the value of the HV as a professional source of information. The two final groups were divided equally between the importance being a consequence of the anxiety felt by the mother (14.6%) or feeling any advice/information concerned with the welfare of their child was intrinsically important (14.6%).

The small group of mothers (n = 6) who felt the advice/information was 'neither important nor unimportant' were not particularly concerned about the issue. This also applied to one of the clients who rated the advice/information 'very unimportant' while the remaining two disagreed with what the HV said.

Generally, clients reported the advice/information and talking with the HV at the CHC were helpful and important. However, as reported (see Table 5.4.6) 62 clients (65.2%) described knowing all or some of the advice/information prior to the CHC visit. These responses raised questions about how these discussions had arisen. This issue is explored in Section 6.4.

Section 6.4 Reasons for discussion with the health visitor

The 62 clients were asked *why* they discussed the issue when they knew all or some of the information. This question elicited a variety of responses which were subsumed by the researcher under four main categories (see Table 6.4.1 and Table 6.4.2).

6.4.1 Clients who reported knowing all the advice/information

The reasons given by the 33 clients who reported already knowing all the advice/information given by the HV for discussing this issue are shown in Table 6.4.1.

Table 6.4.1: Advice/information known - reason for discussion (child health clinic)

Reason	Number
Checking	11
Reassurance	10
Professional opinion	8
HV raised the issue	4
Total	**33**

Checking

The largest group (n = 11) of responses concerned clients using the HV to check an issue. Sometimes this was regarding advice/information the mother had received from another source. In addition, clients described using the HV to verify that an aspect of their child care was correct.

(Client 20)

'I needed to know if I was doing the right thing or the wrong thing.'

(Client 25)

'Things change all the time like this thing with the weetabix, I wouldn't have thought. I started my daughter when she was about four or five months. Nowadays you are advised not to until a certain age where as you wasn't before. So I think that things are changing all the time, the do's and the don't are changing all the time.'

(Client 55)

'Different people tell you different things so before I did anything I wanted to check with the health visitor.'

Reassurance

Some clients (n = 8) used the term reassurance to describe why they had talked with the HV. The clients sought reassurance that their child was progressing normally and that the mother was performing child care correctly.

(Client 5)

'I wanted reassurance that everything was okay.'

(Client 24)

'To make myself feel a bit better I think more at ease that everything was okay.'

(Client 54)

'I felt anxious and I wanted reassurance from the health visitor.'

Professional opinion

Seven clients emphasised the expert nature of the HV's role in the CHC. The perception of her as a professional source of advice/information was important to these mothers. Most (n = 6) of this group mentioned the word professional in their description of why they chose to discuss an issue.

(Client 37)

'She is qualified in that area [child care]. *It gives you peace of mind talking to a professional. You know you will get the right advice.'*

(Client 28)

'It was getting a professional opinion. A second opinion to confirm what I thought. Health visitors have had lots of experience.'

One client did not use the word professional but was included in this group because her description appeared to imply that she was using the HV for her professional opinion.

(Client 3)

'This is my first child I am still not certain how to bring her up properly, I want to do it the right way. I want to be sure I am doing everything properly, that I am not doing anything wrong.'

HV raised issue

A small group of clients (n = 4) explained discussions instigated by the HV. In two cases, the HV was enquiring about the progress and treatment of a child's chronic illness.

(Client 7)

'She brought it up, it showed that she was interested in him.'

In the remaining two instances, the HV introduced advice/information already known to the mother without checking whether it was relevant to the client.

(Client 100)

'I already knew that stuff about the fireguard, and the socket and things.'

6.4.2 Clients who reported knowing some of the advice/information

The reasons given by 29 clients already knowing *some* of the advice/information for discussing this issue are shown in Table 6.4.2.

Table 6.4.2: Some advice/information known - reason for discussion (child health clinic)

Reason	Number of clients
Checking	14
Reassurance	10
Wanting extra information from HV	4
Informing HV	1
Total	**29**

Clients who knew all the advice/information and clients who knew some of the advice/information gave the same reasons for their discussion with one exception. Four clients in the *knew some* group reported discussing the issue in order to get more information.

Most mothers were again checking information or seeking reassurance that all was well regarding some aspect of child care or health. This was similar to those in the knew *all* information group.

Checking

(Client 16)

'Basically because I didn't know if it was the answer. I had an idea of some things to do but I thought well she's got the experience she most probably knows, she's had experience of babies doing the same. Its quicker that way

than trial and error.'

Reassurance

(Client 40)

'Being a first time mum I need reassurance. At the back of my mind I knew it, I just need it confirming.'

To get more information

Four mothers said they wanted additional information from the HV to do with their child's health.

(Client 4)

'To see if she [HV] *had anything different, different information.'*

(Client 49)

'Its more reassuring from a person, you get better feedback, extra information.'

Informing the HV

In one case the client raised an issue in response to a general inquiry from the HV.

(Client 58)

'She said "oh have there been any problems"? And I said oh well she had this rash last week and so I was telling Susan [HV] *and of course she said about Dr Lea changing health visitors. I said don't mention his name to me and she said, "oh what's the matter" and we got talking about it.'*

Summary

Most (n = 19) of those who already knew the advice/information were using the HV to check information that they already had or to check what they were doing in some aspect of child care. A smaller number of mothers (n = 10) sought reassurance from the HV. In two cases mothers indicated the discussion was irrelevant because the HV introduced and spoke about an issue about which the mother was already informed.

Similarly, those mothers who knew *some* of the advice/information reported using the HV to check information, to reassure themselves or to get additional information.

Having recorded why mothers discussed an issue, the outcome of this exchange between the client and HV was then examined.

Section 6.5 Use of advice/information

All respondents were asked whether they had *used* the advice/information given by the HV (see Table 6.5.1).

Table 6.5.1: Use of advice/information (child health clinic)

Use of advice/information	Number of clients	Percentage
Had/would use	62	67.4%
Reassurance	17	18.5%
Would not use	6	6.5%
Have used some information	3	3.3%
Not sure	1	1.0 %
Other	3	3.3%
Total	**92***	**100%**

* Missing data for 8 clients who did not recall a discussion with the HV.

Clients who would not use the advice/information

Of those who said they *would not* use the information (n = 6) three had wanted information from the HV but were dissatisfied with the information given and dismissed it.

(Client 44)

> *'They interfere, they try and tell you, but they don't like tell you what you want to know, its what they think you should be doing.'*

Three clients had not wanted to discuss the issue which was raised by the HV, they felt the information was irrelevant.

(Client 51)

'It was not much help really. It would have been pointless to come home and done that, because I would have had the same problem anyway.'

Clients who had used some of the information

Two clients had only used part of the advice/information because the discussion had not been totally satisfactory from their perspective.

(Client 23)

'Yes, I can see what they say about me giving him more food, but giving it at supper time I disagree with, in that way it was unhelpful.'

(Client 46)

'I still felt like I was getting conflicting information, I still didn't know what to do.'

For one client data were missing for the follow up question regarding why they had only used some advice/information. Therefore no comment could be made about whether this reflected dissatisfaction or simply a lack of opportunity to use all the advice/information.

Clients who might use some of the information

(Client 94)

'Not sure whether she would use the advice/information on diet because she had not yet seen leaflets that the health visitor had agreed to get for her.'

[Taken from interview notes]

Reassurance

Seventeen participants received information/advice from the HV which reassured them their child was developing normally (n = 7) or resolved the mother's concern about a suspected problem with their child's health or diet (n = 10).

(Client 28)

'Just to inform me about the her [baby's] *growth and everything, her weight, and to tell me she was doing fine.'*

(Client 47)

'Because I've sat with it for like a good three months and I thought there's something wrong with her even though I knew she looks well. The afternoon clinics are a bit of a pain, because I work in an afternoon. So I had to go, I had talked about it with doctors and that but no joy. She told me there is a lot of babies like this, she told me there is such a thing as a sicky baby which I didn't know. She can tell me, she sees a lot of babies so I believe her.'

(Client 70)

'It was a few weeks since I had Emma checked and weighed so obviously I wanted to make sure that she was progressing healthily.'

Other

Two clients had been updating the HV about the progress of their child at hospital appointments.

(Client 81)

'She [ill child] *just comes up in the conversation like. Its nice to know that she* [HV] *thinks of her, its good that the health visitor remembers her and that, she's always asking how she is.'*

One client was already using the information supplied by the HV (the client's need for the information had not been ascertained).

(Client 100)

'I already knew that stuff about the fireguard, and the socket and things.'

Summary

Few people who discussed an issue with the HV decided that they would not use all or

some of the advice/information but when this response occurred it indicated dissatisfaction with what the HV had said.

A sixth of the discussions between client and HV did not result in a demonstrable outcome in terms of action but rather in the client being reassured on some aspect of their child's care, progress or management.

For some clients no outcomes were reported because they did not recall any discussion with the HV. In addition, a number of mothers reported that they were attending the CHC *only* to have their child weighed. The responses of these two groups of clients were examined as they might suggest that the HV was not required in these instances. These responses are reported in the final section.

Section 6.6 Clients with no memory of a discussion with the HV

The interview schedules and audiotape data for the eight clients who did not remember holding a discussion with the HV were examined.

There appeared to be a general lack of importance attached to seeing the HV by seven of this group. This was ascertained by asking whether it had been important to speak with the HV on that CHC visit. Four clients said that it was very unimportant to speak to the HV at the CHC. When asked why, two clients said that they only wanted the child weighed and this did not necessitate talking to the HV. The eighth was attending for a check with the doctor.

(Client 35)

> *'Mainly to check the weight* [attending CHC] *because she has reflux, and so weight is important but not talking to the health visitor.'*

The remaining two clients stated that they were quite happy with their child's progress, had no concerns and therefore did not need to talk to the HV.

(Client 79)

> *'I don't usually ask* [the HV], *I brought the other three up on my own, so I*

know what they're like. I only go for her weight , I knows she is OK already, I go to see how much it is really, how much weight there is.'

One of this group said that it was fairly unimportant. She explained that anyone could have weighed her child because everything was okay and there was there was no problem with her child.

(Client 90)

'Anyone could have weighed her, because everything was okay, there was no problem.'

Two mothers said that it was neither important nor unimportant to see the HV at the CHC. One mother explained it was important to have the weight written down on the records but it was unimportant because there was nothing to ask the HV. The second mother also commented that she simply had nothing she wanted to *ask* the HV.

(Client 77)

'They are there if you want to talk to them but there wasn't anything that I wanted to discuss.'

The eighth client who did not remember any discussion still rated it very important to talk with the HV. This participant appeared to view the contact in the CHC as a check for their child, but had no memory of the information that the HV had attempted to give regarding infant feeding practice.

(Client 21)

'In case there's anything wrong. We can go and see the health visitor and she can help us sort things out.'

Summary

It is not possible to know precisely why some clients did not recall a discussion with the HV. Most of this group described finding out the weight of their child as both the reason for visiting the CHC, and for not judging it important to talk with the HV.

Section 6.7 Clients who said they were attending the child health clinic for weighing only

Nearly a third (n = 30) of the participants stated that they were coming to the CHC for weighing only. These responses raise the question whether this group of clients required a HV service. This group of mothers all spoke with the HV and examination of the data showed that a possible mismatch between intention for visiting the CHC and actual outcome was explained in one of the following four ways (see Figure 6.7.1).

Figure 6.7.1: Mothers who said they were attending the child health clinic only to have their child weighed

- Mothers said they were attending for weight only, and were offered unsolicited advice/information by the HV
- Mothers said they were attending for weight only, but actually intended to discuss an issue
- Mothers said they were attending for weight only, but solicited advice/information from the HV once at the CHC
- Mothers said they were attending for weight only, but this included discussion with the HV

6.7.1 Mothers who said they were attending for weight only, and were offered unsolicited advice/information by the health visitor

Seven of the 30 mothers who stated that they were only visiting CHC for their child's weight did not remember receiving any information at the CHC (see 6.6). One mother felt it had been fairly unimportant to talk with the HV at the CHC. Although this was apparently was a decision based on the knowledge that the baby's weight was satisfactory:

(Client 90)

> *'Anybody could have weighed her I could have done it myself couldn't I, but if the weight hadn't been satisfactory it would have been very important to have spoken with her. So she needed to be there just in case, though it didn't necessarily need to be her that did the weighing though.'*

Two of this group rated the importance of talking to the HV as neither important nor

unimportant:

(Client 77)

> *'Because all I really wanted was to see how his weight was going. I'd already spoken to her about his feeding habits earlier really, so I didn't think it was really necessary to see her anyway.'*

The remaining four respondents rated talking to the HV at the CHC as very unimportant:

(Client 89)

> *'Its just to get her weighed, no need to ask the health visitor anything.'*

The mothers' lack of interest in talking to the HV appeared to be predominantly because they had no worries about their child, so the HV was unnecessary.

A further eight mothers did recall advice/information discussed with the HV but in each case commented that it was the HV who had introduced the subject.

Two appeared fairly hostile to the whole exchange, describing feeling patronised and forced into listening to the HV's opinions regarding care of their child. One mother reported it was very unimportant to speak with the HV and the second mother described the discussion as fairly unimportant.

(Client 15)

> *'They think that everyone is like a first time mother, they don't know nothing. But like when I had Jimmy* [first child] *I like listened to all their advice, but I learned from my mistakes and now I know with her* [second child] *like what they are saying is no good to her, it don't help at all.'*

A further four clients who described it as very unimportant to talk with the HV did not report the unanticipated advice/information as of value but were not critical of the HV

introducing the issue:

(Client 100)

> *'Because I really basically wanted to know how much she weighed, and get my milk.'*

By contrast the remaining two mothers had been invited by the HV to describe the current status of long-standing problems of one of their children. Both of these mothers valued the interest and concern shown by the HV in the child's progress but did not see it as a *necessary* part of the CHC visit, as *their* main concern was the weight of the child. The selected levels of importance were neither important nor unimportant for one client and fairly unimportant for the other mother.

(Client 7)

> *'I had discussed everything with the physio and with other people. Obviously it is important for her to know everything and be up to date, but it didn't really matter about me talking to her because I had already discussed it with other people anyway. Nothing has really changed with Drusilla, so I just literally went to get her weighed, and not to talk to anyone in particular.'*

These 15 clients appeared primarily interested in attending the CHC to weigh their child. This remained the case even when clients recalled the discussion they had held with the HV. Thirteen of the discussions were raised by the HV.

6.7.2 Mothers who said they were attending for weight only, but actually intended to discuss an issue

Nine mothers who reported weighing as their only reason for visiting the CHC *apparently had a prior intention* to discuss a specific issue with the HV. This intention became evident from examination of the audiotapes and interview questionnaires.

Seven mothers were concerned with the weight of their children including: illness, worry that the child was not eating sufficiently due to a change in eating pattern, inquiry about the child's diet. Two clients asked the HV about the child's sleep pattern and an ante-natal

problem respectively.

Two clients reported that it had been neither important nor unimportant to talk with the HV at the CHC but the remaining seven described the discussion as fairly important (n = 4) or very important (n = 3).

The length of these interview extracts allow the reader to note the emergence of evidence that suggests that these clients had a prior intention to ask the HV about an issue.

(Client 38)

line 1 - Interviewer: *'What was the main reason for your visit to the child health clinic?'*

line 2 - Client: *'To keep an eye on her weight.'*

line 3 - Interviewer: *'Was it just to get her weighed only or was there something behind getting her weighed that was worrying you?'*

line 4 - Client: *'Yeah, Because she hasn't been gaining weight in the past few weeks, she'd been in hospital and they suggested that she get weighed twice a month just to make sure her weight gain, it is there, is increased.'*

line 5 - Interviewer: *'Did you talk to the health visitor whilst you were at the clinic?'*

line 6 - Client: *'Yeah, I asked whether it was worth swapping the formulae milk she's mainly breastfeed but she tops up. But lately, she'd been refusing, maybe the taste wasn't too similar to breastmilk and whether it would be better for her to swap to another milk.'* .....

line 7 - Interviewer: *'Can you give me a little more detail about why it was fairly important to talk with the health visitor at the clinic?'*

line 8 - Client: *'To get information to know how best to continue, after her being in hospital, with her still having the diarrhoea.'*

Comment: In line 2 the client establishes she is attending for the weight of her child. Line 6 identifies a change in feeding prior to the CHC visit. Line 9 links talking with the HV with the mother's concern regarding ongoing symptoms.

(Client 18)

line 1 - Interviewer: *'Why did you attend the clinic?'*

line 2 - Client: *'To weigh Leslie.'*

line 3 - Interviewer: *'Was there any other reason for your visit?'*

line 4 - Client: *'No.'*

line 5 - Interviewer: *'What was the most important thing that you talked with the health visitor about?'*

line 6 - Client: *'About her food the way that she is eating it.'*

line 7 - Interviewer: *'Did the health visitor bring up the subject?'*

line 8 - Client: *'No, I did.'*

line 9 - Interviewer: *'Can you tell me why you brought this up?'*

line 10 - Client: *'She wasn't eating, she was drinking her milk, but she wasn't eating.'*

line 11 - Interviewer: *'And why was this important to you?'*

line 12 - Client: *'Because I didn't want her to go hungry, I didn't know what to do.'*

line 13 - Interviewer: *'When you say she wasn't eating can you tell me what had happened?'*

line 14 - Client: *'I don't know, first of all she went off her milk and she wouldn't drink that, and she would just eat her solids and then she started drinking her milk again but she wouldn't eat her solids.'*

line 15 - Interviewer: *'And how long a period of time had this been happening over?'*

line 16 - Client: *'Throughout summer, a couple of months.'*

When asked why she had talked with the HV about this the client replied:

line 17 - *'Just to make sure if I was right about not giving her it if she's not hungry and just to make sure that she was all right really.'*

Comment: In line 2 mother responds she is only attending for the weight. However, in line 8 the client identifies that she introduced the issue. It may be that the issue was not a reason for *attending* but line 17 suggests the mother wanted advice about an issue that has been occurring for some time (line 14).

(Client 52)

line 1 - Interviewer: *'Did she bring up about the feeding or did you?'*

line 2 - Client: *'I think I brought up about the feeding.'*

Comment: At the beginning of the interview the client stated she was only attending for the child's weight. Subsequently, the mother described how she had discussed the child's diet with the HV.

line 3 - Interviewer: *'So there was some concern whether he was getting enough milk?'*

line 4 - Client: *'Yeah.'*

line 5 - Interviewer: *'How long like has he been like this with his milk Mrs Shield?'*

line 6 - Client: *'About four months.'*

line 7 - Interviewer: *'If it had been going on for a few months was there something particular that had come up that you thought I'd better check it out now?'*

line 8 - Client: *'Well its just that I was giving him bottles and he just wasn't taking them, he was refusing them, and though I know babies should take the milk, its good for them I hope, I don't want to miss out on anything so I thought I'd go and check.'*

Line 6 identifies an issue that has existed for some time. Line 8 '*... so I thought I'd go and check'* suggests premeditation regarding asking the HV about the issue.

6.7.3 Mothers who said they were attending for weight only, but solicited or received advice/information from the health visitor once at the child health clinic

Three mothers described thinking of an issue to ask the HV whilst they were at the CHC. One mother reported it was fairly unimportant to talk with the HV about the issue. The remaining two clients regarded the discussion as fairly important and very important respectively.

(Client 96)

'Wasn't really important but you know, I wanted to know whilst I was there.'

(Client 12)

Interviewer: *'Who brought that up did the health visitor mention it first, or did you mention it first?'*

Client: *'I mentioned it first.'*

Interviewer: *'What was important about that to you.'*

Client: *'I just wanted to check which foods he could have. He is six months old and she said basically he can everything apart from eggs at about eight months.'*

Interviewer: *'When you took him to the clinic it was just to get him weighed did you have tucked away in the back of your mind I might just ask about the foods or was it something that just came up at the clinic.'*

Client: *'Just came up at the clinic.'*

Interviewer: *'Can you give me a little more detail about why it was fairly important to talk with the health visitor at the clinic?'*

Client: *'To clear things up, it refreshed my memory about what to do.'*

The final client in this group although apparently not intending to discuss the child's recent illness with the HV, introduced the issue in response to a general inquiry from the HV. The mother reported that talking with the HV had been very important.

(Client 33)

'I didn't feel that her infection was a problem I wasn't worried about it. It was just brought up in conversation I didn't go to the clinic thinking oh I'll ask her about this, I'll ask her about that ... after what she told me I would say that it was very important to that I went to see her but I didn't go with the intention of asking her that, but I'm glad I did otherwise I wouldn't have known.'

6.7.4 Mothers who said they were attending for weight only, but this included discussion with the health visitor

As described above, 15 clients reported that they visited the CHC solely to find out the

weight of their child and that this did not necessitate discussion with the HV. However a few mothers (n = 3) who had also recorded that they visited the CHC only to find out the weight of their child perceived that this *would* include talking to the HV. Two mothers reported that it was fairly important to talk with the HV and one mother that it was very important.

Two mothers who were regular attenders reported no problems with their child, but expressed the opinion that regular weighing demonstrated the satisfactory progress of the child. Both parents reported that the discussion of the weight, and confirmation by the HV that weight gain was synonymous with satisfactory development of the child, provided reassurance to the mother.

(Client 5)

> *'Susan* [the HV] *is always helpful when you go, she's ever so nice, she's always asking questions if you have ought to talk to her about, she's always there to listen.'*

This client described talking about the progress of the baby as helpful, because:

> *'To know everything is okay, to be prepared, that's why we go to the clinic for the reassurance, nine times out of ten there's nothing wrong anyway.'*

(Client 28)

> *'I like to see the graph and see how its going along the line and everything because sometimes they go up and down don't they ... with all their* [HVs] *experience that they have with them being professional, its like a second opinion isn't it.'*

The third mother illustrated the importance of her child's weight with reference to her previous feeding difficulties. Once again, just *seeing* the weight was not sufficient for this mother. The extract from the text illustrates the degree of anxiety and importance that weighing may hold for the mother.

(Client 91)

Interviewer: *'What was it about the weight that you were interested in, that concerned you?'*

Client: *'... previously when I had been in hospital because I was in for quite a while with Linda, and she had maybe gained a couple of ounces in the time that we were in there, in the ten days, and to come out and see her gain so much weight in a short period of time was really good for me because she had been put down as a problem feeder ..... She had four days from birth when she was fed intravenously and then on the fifth day when my milk came in we then started to feed her, I was quite engorged, she couldn't latch on and we had a couple of days that weren't, that weren't very successful but we had had the drip taken out so that we persevered with the breastfeeding and from the sixth day to the tenth day she started to feed and feed well and on the tenth day we went home ..... because of those initial troubles that we had and the fact that we couldn't go home until her weight had turned and she started to gain weight then when her weight dropped, and then turned, it had only turned by about half an ounce that didn't seem very much at all. Then after being home from Saturday to the Thursday she had gained two ounces and then from the Thursday to week Monday she had put on 1lb 4 ounces so that weight build up was really important. Now any worries that I might have had about her feeding properly and although she has never been xx* [Indecipherable words on the tape], *you are still never really certain how much milk they are getting with the breastfeeding.'*

In response to the question of whether it was important to talk to the HV at the CHC this client explained:

Client: *'I could have weighed the baby myself and seen the weight growth but I would still have had a nagging feeling if there had been no one to talk to.'*

Summary

Half those who said that weighing was the sole reason for the CHC attendance appeared to confirm this in their rating of importance of talking with the HV. The majority of these

responses were fairly unimportant or very unimportant. By contrast, the other half of those who stated they were attending for weighing only, included mothers who wanted to ask the HV a question, thought of an issue at the CHC or regarded finding out about their child's weight as involving discussion with the HV. The majority of this latter half considered it either fairly or very important to speak with the HV at the CHC.

CHAPTER 7

DISCUSSION OF FINDINGS FROM THE CHILD HEALTH CLINIC VISITS

The following aims were identified for investigation of the work of the health visitor in the child health clinic:

- to identify clients' recall of issues discussed
- to examine clients' reports of advice/information from health visitors
- to examine clients' reports of use of this advice/information.
- to describe clients' accounts of the value of this advice/information

This section discusses the quantitative (Chapter 5) and qualitative (Chapter 6) findings and places them in the context of issues raised in the literature review of CHC visits (Chapter 3).

The literature review suggested that mothers attend CHCs for reasons other than developmental screening or medical services (see Chapter 3.2.4). Moreover, CHCs are a regular work commitment of most HVs. It is therefore of interest to examine to what extent, if any, the HV provides a service when clients are not attending CHCs for developmental screening or medical services. In addition, it is argued (Hall, 1996) that the emphasis of services should move away from secondary prevention including developmental screening towards primary prevention incorporating client centred health promotion activities. Such a shift provides a rationale for examining the HV's work, other than secondary prevention, such as her traditional advisory role.

The current study builds on the work of previous researchers who have reported the work of the HV. Past studies have encountered difficulties in clearly establishing what services HVs actually provide for clients, or whether their presence was relevant to mothers attending CHCs. In addition, methodological weaknesses of previous research (see Chapter 3.5) had limited the abilities of these studies to link reports of client satisfaction with the HV work.

The current study is a response to these issues and this chapter provides the opportunity to establish the extent to which the issues raised in the literature review have been addressed by the quantitative and qualitative findings of the present investigation. The main elements of this discussion will review whether, as some research has suggested (Bolton, 1984; Sharpe and Loewenthal, 1992), clients primarily attend CHC to obtain the weight of their child, review the advisory role of the HV, and examine specific elements of satisfaction that the current study investigated.

Section 7.1 Do clients attend the child health clinic solely to obtain the weight of their child?

CHCs are visited by mothers on a voluntary basis and there has been debate in the literature as to the motivation for these attendances. The impression from some research findings is that weighing the baby is an important reason and for some mothers the most important reason for attending (e.g. Biswas and Sands, 1984; Morgan et al., 1989; Sharpe and Lowenthal, 1992).

To what extent is the HV necessary to weighing? If, for the mother, weighing the baby is a matter of placing the baby on the scales, noting the weight and leaving the CHC, this may imply that the HV should be replaced by a unqualified member of staff, or indeed that no health worker is necessary for this service.

The current study found that weighing the baby was an important feature of the CHC visit for mothers. Over four fifths (n = 85) of clients selected this as a reason for visiting the CHC, and 30 said they were *only* attending for weighing. However, as a consequence of asking mothers to rank the importance of reasons they gave, it emerged that although over half the mothers selected weighing as the most important reason (n = 53), 45 mothers selected another issue (that was subsequently discussed by them with the HV). Overall, 71 clients were identified as intending to raise an issue other than weighing with the HV.

Comparing this finding with results from other studies is problematic. Two previous investigations (Acheson, 1962; McIntosh, 1964) also reported a high percentage (62% and 67.6% respectively) of respondents receiving advice from the HV. However, the researchers in both studies arrived at these figures by *assuming* that the act of weighing

involved advice being given by the HV. As there is no evidence of all the client/HV interactions being observed it is impossible to know to what extent these figures actually *do* represent advice received by mothers.

Other studies (e.g. Sefi and Macfarlane, 1985; Sharpe and Lowenthal, 1992; Quine and Povey, 1993) have reported lower numbers of clients reporting seeking advice from HVs, but methodological problems such as multiple categories for advice, collecting data retrospectively and asking clients about several rather than specific CHC attendances may have produced artificially low or high numbers of responses from clients regarding advice. By contrast the present study asked mothers within approximately a week from a CHC visit to focus on their reasons for attending on that *one* occasion. This information was supported by observational data from the CHC visit. Therefore, the current investigation was able to avoid the pitfalls associated with a reliance solely on respondents' recall of multiple CHC visits, producing a more authentic picture of clients' reasons for visiting the CHC on a particular occasion.

Aside from these methodological differences, the main problem in comparing the findings of the current study with previous investigations is inclusion in the current study of only those clients *not* attending for developmental checks or to see the doctor. Consequently this may have produced an unusually high number of responses from clients saying they wanted to discuss an issue with the HV. This introduces problems in comparing findings with the majority of other studies, which have examined other elements of the CHC service including developmental screening, immunisations and advice from the doctor.

The present investigation reports the highest recorded number of clients in any study who identify wanting to discuss an issue with the HV (71%). However, this finding cannot be used to suggest the methodological difficulties of previous research led to an under reporting of the number of mothers who did in fact seek advice from the HV, although this may have been so. In previous studies methodological constraints have resulted in a failure to clarify the interaction between the HV and the client in the CHC. Therefore, the value of the current study lies in describing what *actually* occurred when clients either attended a CHC to have their baby weighed or when they talked with a HV.

The current finding regarding reasons for attendance supports previous findings that report the importance to the client of weighing. However, it also qualifies this apparent importance by showing that attending for weighing does not preclude wanting to use the HV service for other reasons. The findings also demonstrate that the expression 'to get the baby weighed' reflects a continuum of possible issues and levels of concern that may be felt by the client. Thus, weighing may involve a desire by the client to speak with the HV. This could be inferred from an earlier study by Gastrell (1986, p 79) from her comment: "from discussion with mothers it would appear that weighing the baby involved more than a recording of weight", but she failed to amplify this statement or provide supporting evidence.

This issue arose with the thirty per cent of mothers in the current investigation who stated that they were attending CHC solely for the weight of their child. Evidence emerged that suggested that this stated intention did not always correspond with subsequent descriptions by the mothers of their reasons for attending the CHC.

During discussion between the researcher and client regarding their CHC visits, 12 mothers revealed a prior intention to speak with the HV about an issue, or explained that having the child weighed *involved* discussing the child's general progress with the HV. A further three clients discussed an issue opportunistically with the HV. Eleven of this group of 15 mothers felt it had been fairly or very important to speak with the HV. Thus, just over a third of those who stated that they were attending the CHC only to get their child weighed had contact with the HV other than this, which they regarded as beneficial. This illustrates the difficulty of achieving an accurate understanding of clients' intentions and that descriptions of intentions may not always reflect behaviour.

The problem for health visiting arises if studies report figures for weighing without an adequate examination of what else the client attends for, the relative importance of interventions to the client and what actually happens in the CHC. To clients, as the present study suggests, the notion of weighing may cover many potential issues and levels of concern. It also may or may not involve a perceived need by the client for a HV service.

Another aspect of weighing was raised in the literature review. Sefi and Macfarlane (1985, 1987) and Sefi and Grice (1994) reported a disparity between answers received to two questions. Clients were asked their reason for attending the CHC that day, and also about the perceived benefits of attending. Weighing did not appear as a perceived benefit in the studies though it figured largely as a reason for attending. Conversely, meeting other mothers did not appear as a reason for attendance but was rated highly as a perceived benefit in the earlier studies (Sefi and Macfarlane, 1985; 1987). Consequently, the authors reasoned that for many mothers CHCs can provide a social function but suggested that (Sefi and Macfarlane, 1985, p 129):

> *'This may not be initially revealed by mothers who use the popular reason for attendance of weighing as almost an admission ticket to the clinic. Many mothers could weigh their baby in the chemist shop, if not at home, but most appear to prefer coming to the clinic.'*

Why it should be necessary to interpret the client's description of weighing as an admission ticket is not clear. The implication of an admission ticket is that you cannot gain admittance to an event without it. The authors did not provide any rationale for why clients should be unable to admit, as apparently mothers in other studies had been able to do (Orr, 1980; Biswas and Sands, 1984; Bolton, 1984), that social contact was a reason for attendance.

It *might* be argued that mothers did not feel meeting other mothers was a legitimate reason for attending the CHC, so that they disguised the primary desire for social contact with the excuse of wanting to weigh the baby. Twelve percent of the sample (n = 127) (Sefi and Macfarlane, 1985) selected weighing as their main reason for visiting the CHC and therefore may have been really attending for social contact according to the authors. However, the majority of people who gave weighing as a reason for attending (n = 515) did so in addition to *another* reason. Presumably, clients only required one 'legitimate' reason for entrance to the CHC so it is unclear why they should feel compelled to mention weighing *unless* it had some meaning for them.

This suggests that for the researchers, weighing might have appeared too trivial a reason to be the true motive. However, the linkage between the child's weight and concerns about its progress or health expressed by the mothers in the current investigation makes it plausible that clients perceive issues to do with weight as meriting attendance at a CHC. It may be that clients choose the CHC and not the chemist because having a child weighed for most mothers is not restricted to looking at the result on a scale.

Additionally, there may be a difference between the main reason a person gives for carrying out an action and something that arises as a benefit from that action. Therefore, it may be that meeting other mothers *was* recognised as a gain but not thought *sufficient* by mothers as a reason for attending.

For some clients, reasons for attending CHC and what is gained from the visit may be equivalent, which would account for why advice from the HV and advice from the doctor were described both as a reason for attendance and a perceived benefit, although it is not possible to establish from the original paper if these were selected on the different occasions by the same mothers.

Finally the disparity between the responses to the two questions may arise from methodological confusion. It is not clear from the text (Sefi and Macfarlane, 1985; Sefi and Macfarlane, 1987; Sefi and Grice, 1994) whether clients were asked about the perceived benefit of a particular CHC attendance or in more general terms. If the question was intended or perceived by clients as asking them to describe the benefits *generally* of attending CHCs then it is debatable to what extent these general comments can be thought to reflect on reasons for attending the CHC on a specific occasion.

A different methodological point is that it may simply be easier for mothers to use the term 'to weigh the baby' as a shorthand reply to researchers' questions about attendance. In the current research, it was only during discussion with mothers about their visit that the stories attached to some responses of 'to weigh the baby' revealed the context of anxiety or concern.

However, 'to weigh the baby' appeared to imply precisely that for some mothers, as they reported how they were *solely* interested in obtaining the weight and did not introduce any other issues that they had intended to speak with the HV about. However, researchers cannot be sure about the meaning of intentions unless they have sufficient detail. The current study has suggested that previous research into CHCs has lacked sufficient information concerning the client's *actual* behaviour and experience in the CHC.

This builds on the work of Sefi and Macfarlane (1985, 1987) and Sefi and Grice (1994) by moving beyond clients' reported intentions for attending the CHC to an examination of what clients discussed with HVs. Moreover, by following through with each mother their perceptions of this discussion, stronger evidence is provided with which to comment on the HV service, including any perceived benefits.

Two of the CHCs in the present investigation had a system whereby someone other than the HV weighed the baby and the mother elected whether to see the HV following this. The fact that people chose to talk with the HV might suggest that it is not necessary to have the procedure of weighing to act as a catalyst for a discussion between HV and client. Furthermore, this lends substance to the idea that mothers come to CHCs with their own agendas, including more than just an interest in establishing the weight of their child. Clients' needs and perspectives expressed within this study provide support for Hall's (1996) recommendation for a partnership approach and a service orientated to satisfying *client* defined needs (see Chapter 3.2.5).

Section 7.2 Advice and information giving role of the health visitor in the child health clinic

Part of the role of the HV in the CHC has been involvement in delivery of immunisations and screening programmes in conjunction with other colleagues. The current study focused on describing the work of the HV in addition to their role with medical aspects of the CHC service.

Previous research has reported clients stating that they were attending the CHC for advice, but it was not clear in some of these studies whether the client sought advice from the HV, doctor or other CHC worker (e.g. Steiner, 1977; Karmali and Madeley, 1985; Gastrell,

1986; Quine and Povey, 1993). Some studies have identified the HV with advice but the rates of those identifying the HV as a source of advice vary widely between studies.

A further problem arises from the reporting of discussions between HV and client. Until the present investigation we have confusing accounts of clients' contacts with the HV, including descriptions of 'chats' (Morgan et al., 1989). One researcher (McIntosh, 1964) observed that there was no dividing line between advice and non-advice in discussions between the HV and the client. He argued that the HV simply telling the mother the weight of her child could count as advice. A variety of descriptive terms offering different interpretations of the work of the HV may obscure either a valuable or trivial service.

The present investigation included observation of the actual discussion between the HV and the mother. Thus, the study *is* able to provide commentary on the 100 observed mothers who discussed an issue with the HV, illuminating both the nature and the impact of the HV service by asking them about this discussion after this event.

The finding that emerges firmly from the study is that advice/information giving was a feature of the HV's work in the seven CHCs observed. The only other study (Leggettt, 1985) which has provided any details of discussions between the HV and the client offered a limited description. The author notes that it is interesting that 41.6% of the advice given was concerned with child development. However, she does not describe what child development actually entailed. It is unclear whether CHCs included in the study also carried out screening checks in which case child development may have related to issues concerned with assessing the child. If this were the case, Leggettt's study also recorded issues discussed during developmental screening checks. While this may be interesting in itself it would reduce the study's power to describe the advisory role of the HV *outside* their secondary prevention role within screening and immunisations programmes.

The author notes 17 different topics discussed (Leggettt, 1985). In contrast the present investigation is more detailed with a list of 30. The list produced by the current study may represent greater accuracy but alternatively may also reflect increased client assertiveness or higher expectations of HV's knowledge. In Leggett's study it was not clear whether

clients sought or were offered the advice/information. In the current study it was possible to record whether clients raised issues or whether they were raised by the HV.

The current study found that HVs discussed a range of between 1-5 issues with a mean of 2 issues discussed per client. The recording of all 205 issues raised between the HV and client provided clarification regarding their nature. The wide range of topics and their focus on child health and care suggests that the advisory role of the HV in these CHCs was more robust than previous studies have suggested (e.g. McIntosh, 1964).

In the current study feeding issues emerge as the most frequent topic discussed, as noted in previous studies (Steiner, 1977; Leggettt, 1985). The current investigation found the categories of feeding, illness and maternal accounted for over two thirds of issues raised by clients. Feeding and illness issues were also chosen most frequently when clients were asked to select the *most important* issues they discussed with the HV.

Nearly three fifths (59%) of issues were raised by clients and just over two fifths (41%) by HVs. At the least, this finding suggests a degree of client involvement, especially when taken in conjunction with the fact that 71 mothers identified that raising an issue with the HV was a reason for attending the CHC.

Nearly four fifths of all issues discussed between the HV and the client were recalled by the client. In keeping with previous research (Ley, 1993) the current study reports a significant if low negative correlation between the number of issues discussed and the proportion of issues recalled by the client. The current study cannot comment on the extent to which all statements made regarding each issue were recalled. However, examining recall of the issues discussed builds on previous research which reported HVs providing advice (e.g. Cubon, 1987; Sharpe and Lowenthal, 1992), but did not explore the *outcome* of such advice.

Over a third of clients reported knowing all the advice/information previously and nearly a third reported knowing some of the advice/information. These figures might suggest that the nature of the inquiry was trivial, that the content of the HV responses was inadequate, or that clients were forced into a discussion that they did not want or need. The mothers'

explanations of why they discussed issues when they already knew some or all the advice/information that they received did not generally suggest problems of quality or coercion. However, in two cases, mothers did indicate the discussion was irrelevant because the HV introduced and spoke about an issue that the mother was already informed about and had no particular interest in talking about.

Nevertheless, the majority of these mothers had discussed the issue with the HV in order to check information, to reassure themselves or to access additional information. The CHC has been noted in previous studies as a source of reassurance (Cubon, 1987; Sherratt et al., 1991). Some researchers have suggested (Sefi and Macfarlane, 1985, p 130):

> *'Reassurance gained from attending clinic and the social opportunities the clinic can provide are often as important to mothers as professional advice and should not be overlooked.'*

The current study findings suggest that reassurance may arise from some CHC attendances in *response* to a query or concern of the mother's being resolved by the HV. Reassurance from CHC attendance may therefore be an outcome of professional advice and not, as implied by Sefi and Macfarlane, separate from it.

Reassurance emerges again as a way of understanding the use clients made of advice/information received from the HV. Seventeen of the clients described the outcome of their discussion with the HV as reassurance. This reassurance was experienced because their discussion with the HV had confirmed that their child was developing normally, or resolved the mother's concern about a suspected problem with their child's health or diet.

In addition to those mothers who received reassurance, the majority of mothers (n = 62) who recalled a discussion with the HV reported using the advice/information. The knowledge of the role of the HV is increased by investigation of the impact of such activities. These findings provide the first evidence of the use made by clients of advice/information from HVs. Mothers were *not* asked to recall the content of *all* issues they discussed with the HV, so it not possible to comment on their recall of every issue

discussed between client and HV. It does suggest to the mother, at least for the most important issue she identified that the advice/information was relevant and acceptable.

One client was *already* using the advice/information offered by the HV. A further nine clients would not use or would use only some of the advice/information because they disagreed with the content. Realistically it may be inevitable that some mothers disagree with advice/information offered in the CHC. Hall comments (Hall, 1996, p 20) that health staff do not have a monopoly on matters of child care, child rearing or family life. However, such disagreement is important to note. If mothers consistently reject advice/information then this may reflect an unsympathetic and unrealistic approach by HVs or an inadequate HV knowledge base. Although findings in the current study show a low level of dissatisfaction as measured by rejection of the advice/information, HVs should not feel complacent.

The study HVs may have given performances both atypical of HVs in general and of themselves. The fact that the HVs chose to participate in the study might suggest that they were particularly confident and enthusiastic practitioners (Sapsford and Jupp, 1996). Additionally, the presence of the researcher in the CHC may have contributed to a superior performance (Burns and Grove, 1993). Generally, HVs might not be so effective in their advisory role in the CHC, with a consequence that dissatisfaction rates with the advice/information might be higher than those reported in the study.

Additional information about consumer perspectives on the advice/information given by the HV is discussed in the following section. This describes clients' responses to questions regarding the helpfulness and importance of the advice/information received, together with the more general question of the importance of talking to the HV at that particular visit.

Section 7.3 How satisfied is the client with the health visitor service in the clinic?

As the current study was examining the advice/information role of the HV it was appropriate to relate this aspect of their contact with the HV to an inquiry regarding clients' satisfaction. A number of problems have been noted with previous studies which have reported satisfaction rates of clients. The concept of satisfaction was often not defined (e.g. Bolton, 1984; Leggett, 1985) or did not relate to a specific aspect of the CHC service (e.g.

Biswas and Sands, 1984; Sherrat et al., 1991). Consequently, it was difficult to know in what sense a client was satisfied or dissatisfied and what particular feature of their CHC experience this referred to. Additionally, it was not possible to assess the extent to which the HV contributed to high or low satisfaction levels reported by clients.

In the current study, satisfaction was operationalised in terms of two questions which asked about helpfulness and importance of the advice/information received by the client. Mothers were asked to rate the helpfulness and importance of the advice/information on a 5 point attitude scale. This followed the example of Dworkin et al. (1990) who argued that parental perceptions of child health services can be used as an indirect measure of the quality of care. However, the authors focused on the mother's perceptions of *developmental screening checks* carried out by HVs and doctors within the CHC and therefore provided no comment on any other service that the HV might provide.

The present investigation fills this gap by allowing clients to comment specifically on the advisory role of the HV. The finding that over three quarters of clients reported the advice/information was fairly or very helpful and fairly or very important is a positive endorsement of the HV service and of the value of this service to the client. A follow up probe question of why clients selected a particular rating of helpfulness or importance was included in the interview. This provided some understanding about what the service meant to the mother regardless of whether it was perceived as satisfactory or otherwise.

Reassurance emerged as a frequent reason why the advice/information was considered helpful and important. This finding confirms previous studies which highlighted this as a perceived benefit of the CHC (Sefi and Macfarlane, 1985; Sefi and Macfarlane, 1987; Sefi and Grice, 1994) or as a reason for attending the CHC (Cubon, 1987; Sherrat et al., 1991). However, unlike previous studies the current research suggests this reassurance is ascribable to the work of the HV.

An impression of the mother being able to resolve practical issues with the HV is suggested by the references to how the advice/information solved an issue or dispelled a doubt. These findings suggest that the CHC was attended by mothers who had their own agendas in terms of concerns, and indicates that these CHCs were used as a problem

solving service. This may have implications for the degree to which the HVs promote their own agendas in terms of opportunistic health promotion.

This point is highlighted by the fact that 25% of people said that it had been neither unimportant nor important, fairly unimportant or very unimportant to speak with the HV at the CHC. For some of these clients the fact that it had been unimportant to speak with the HV did not appear to have been problematic. However, other clients reported being forced into discussions that they did not feel were necessary and displayed some resentment about this. This suggests the importance of HVs offering advice/information that they have *established* is of interest and relevance to the client. At the least, this should include checking whether a client already knows the advice/information or actually wishes to talk about a particular issue.

Some evidence arose of clients perceiving the quality of advice/information as poor or inappropriate. If CHCs are going to function usefully as problem solving centres, mothers have the right to expect that HVs have an adequate knowledge base. However, it is interesting that negative comments about the quality of advice/information were reported only by a minority. However, the participating HVs may have been particularly confident and enthusiastic practitioners. It is uncertain whether similar high rates of satisfaction would be reported by all HV clients.

The findings in the present study clarify a number of issues concerned with the advisory role of the HV in the CHC. The current thesis argues that previous research has highlighted weighing as a reason for attendance at the CHC without sufficient examination of the implications for the role of the HV. Mothers attending the CHC to weigh their children does not imply that they are not also seeking advice from the HV either in connection with the child's weight or another issue.

Furthermore, the present study provides evidence that advice from HVs covers a wide range of child care and child management concerns. The responses offered by mothers regarding the advice/information together with their descriptions of the importance of talking with the HV suggest the following. HVs offer a service outside the work they carry out in screening programmes and this service is sought by clients. Mothers primarily use

the HV for advice, to alleviate anxiety or for reassurance. Consequently, the current investigation argues that from the mother's perspective the HV can be viewed as providing an important element of the CHC service.

CHAPTER 8

FINDINGS FROM THE HOME VISITS

Section 8.1 Introduction

This chapter details quantitative findings from questionnaires completed by the HVs about clients they saw at home and from the subsequent interviews carried out between researcher and client regarding each such visit.

As stated in Chapter 4.1, the objectives for this part of the study were:

- examination of clients' reports of advice/information from health visitors
- examination of clients' reports of use of this advice/information
- description of clients' accounts of value of this advice/information
- description of the meaning of support to clients

Chapter 8 is divided into four sections which cover these aspects of the quantitative findings:

- characteristics of the sample and visit
- health visitor descriptions of issues discussed during the visit
- client descriptions of issues discussed during the home visit
- examination of the relationship between client and visit variables and recall of information

Chapters 9 and 10 describe the qualitative findings from the home visit. Chapter 11 presents a discussion of the quantitative findings from Chapter 8 and the qualitative findings from Chapters 9 and 10.

Section 8.2 Characteristics of clients and the visit

8.2.1 Participants interviewed

A total of 149 clients were interviewed by the researcher. A further 23 clients were not at home when the researcher visited at a pre-arranged time (n = 17), did not wish to

participate in the research (n = 5) or were excluded by the HV (n = 1). Details of this group are included where appropriate throughout Chapter 8.

The number of clients from each locality interviewed by the researcher is shown in Table 8.2.1.

Table 8.2.1: Participants interviewed (home visit)

Locality	Number of participants
1	26
2	20
3	24
4	14
5	28
6	16
7	21
Total	**149**

Permission for audiotaping was sought and given by all but two participants. Detailed notes were taken during these interviews. A further five visits were unsuccessfully recorded due to recorder error or malfunction of the tape recorder.

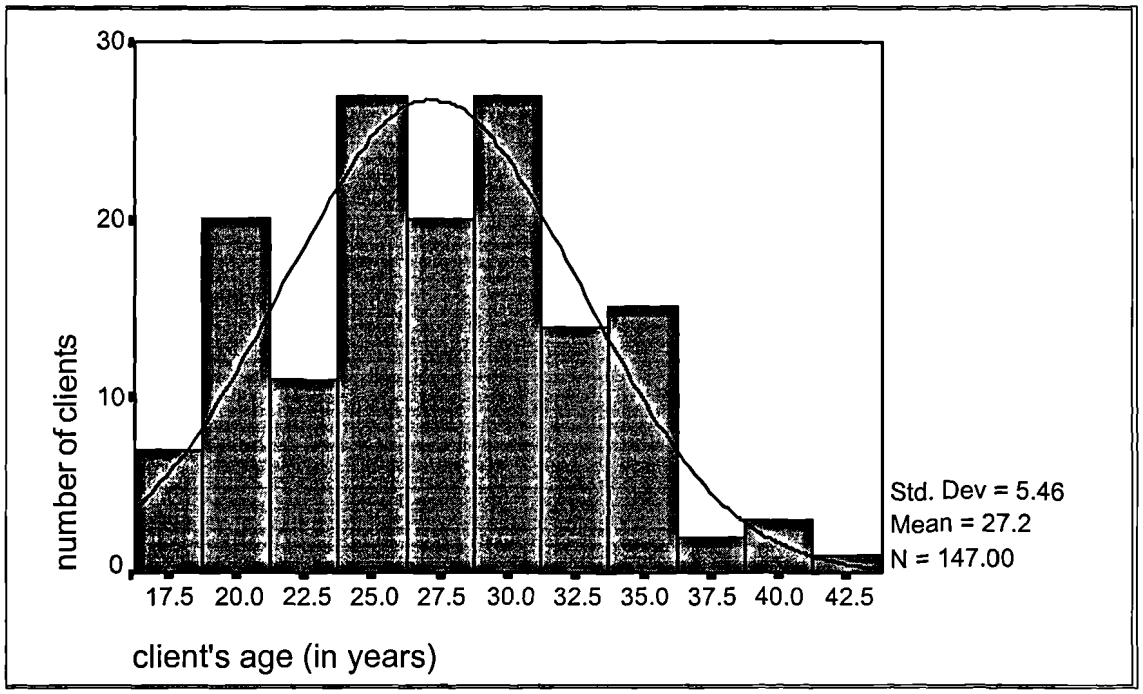
Interview time varied between 20 minutes and an hour. Variability was due to the difference in the amount that mothers had to say and the practical distractions that could occur within households. Five participants were not clear about what was being referred to when the researcher asked about support, 'How do you mean' being a typical response. In these cases when the participant was clearly having a problem recognising such a concept the researcher offered the explanation of 'feeling different or better as a result of the health visitor's visit'. This was accompanied by the statement that it was not necessarily something that the participant would have experienced. The researcher wanted to avoid imposing a definition on the participant or suggesting the idea that support is something that *should* have occurred.

The researcher wrote notes in a field diary usually immediately after visits to record any unusual issues or impressions. This also provided an opportunity to write detailed notes if there had been an audiotape failure or the participant declined to be recorded.

8.2.1 Age of clients

The age of the clients was noted by the HV except in two cases (see Figure 8.2.1).

Figure 8.2.1: Age of clients (home visit)



The mean age of the clients was 27.2 years (SD 5.462), range 26 years (17- 43 years). Examination of the histogram shows the data were approximately normally distributed. Over two thirds (n = 101, 68.7%) of the clients were under 30 years of age.

Of clients who were *not* seen the mean age (25.1 years, range 20 years [18 - 38 years]) was slightly younger than the seen group.

8.2.2 Relationship status of clients

Most participants were living with another person or persons (see Table 8.2.2).

Table 8.2.2: Relationship status of client (home visit)

Status	Number	Percentage of total *
Living with partner	132	88.6%
Living with relative(s)	5	3.4%
Living alone	12	8.1%
Total	**149**	**100%**

* Percentage discrepancies from 100% are due to rounding of individual percentages

For most mothers this meant living with a partner, but for a few (n = 5) involved living with either a maternal grandmother, maternal grandfather or both. Just 8% of the clients were lone parents. This mirrors the national figure of 8% (ONS, 1998) but is less than the local figure of 20% (Garnett et al., 2000).

In the *not* seen group the majority of women (n = 20, 87%) were living with a partner and a further three (13%), were lone parents.

8.2.3 Employment status of households

The majority of clients (n = 105) lived in a household where one or both the couple were employed. When only one partner was working this was usually in full-time employment (n = 64) (see Table 8.2.3).

Table 8.2.3: Employment status of households (home visit)

Employment	Number	Percentage of total
Couples - 1 partner employed	67	45.6%
Couples - both partners employed	38	25.9%
Couples - both unemployed	25	17.0%
Single – unemployed	12	8.1%
Single – employed	0	0%
Living with relative - unemployed	4	2.7%
Living with relative - employed	1	0.7%
Total	**147**	**100%**

When both partners were working, the majority (n = 28) of mothers were employed part-time. Their partners all worked full-time. Where mothers were living with relatives most (n = 3) of these relatives were unemployed. Over a quarter (27%) of the total sample were living in households that were dependent on state benefits, which is higher than both the local unemployment figure of 8.6% and the national figure of 4.8% (Garnett et al., 2000).

In the *not* seen group there was a higher rate of unemployment than in the seen group with 47.8% (n = 11) of households with no working member. This number included the lone parents (n = 3, 13%), none of whom where employed.

8.2.4 Number of children in the household

Health visitors noted the number of children for each client (see Table 8.2.4).

Table 8.2.4: Number of children in family (home visit)

Number of children in family	Number of clients	Percentage of Total
1	56	37.6%
2	57	38.3%
3	19	12.8%
4	8	5.4%
5	4	2.7%
6	4	2.7%
No children	1	0.7%
Total households	**n = 149**	**100%**

One client had no children but was three months pregnant and had experienced a stillbirth in her previous pregnancy. All other respondents seen in the study had between 1 and 6 children. The mean number of children in a household was 2.03 (SD 1.19), range 5 (1-6).

The mean for the *not* seen group was 2.1, range, 3 (1 - 4). The majority (n = 12, 52.2%) of the mothers in this group had two children. Two mothers (8.7%) had three children and a further three mothers (13%) had four children. Just over a quarter (n = 6, 26.1%) had only one child. There was a slightly higher number of women in the not seen group who had two or more children.

8.2.5 Length of visit

Health visitors were asked to record length of time spent with the client (see Table 8.2.5).

Table 8.2.5: Duration of interviews

Time	Number	Percentage of Total
Less than 10 minutes	0	0%
10 - 15 minutes	2	1.3%
16 - 29 minutes	11	7.4%
30 - 59 minutes	101	67.8%
60 minutes or longer	35	23.5%
Total	**n = 149**	**100%**

Very few (n = 13, 8.7%) visits undertaken in the current study took half an hour or less, two thirds (n = 101, 67.8) lasted between 30 and 59 minutes, whilst nearly a quarter (n = 35, 23.5%) of visits took 60 minutes or longer. Whilst methodological differences make comparisons with earlier studies difficult, the length of visits in the current study appears longer than in previous reports (Clark, 1981).

Broadly similar findings were apparent in *not* seen group. Just over a fifth (n = 5, 21.7%) of visits took 60 minutes or longer. Nearly three quarters of visits (n = 17, 73.9%) took between 30 and 59 minutes. The final visit (4.3%) took between 16 and 29 minutes.

8.2.6 People present during the visit

The HV noted with whom she had discussed issues and the numbers of people who were present during the home visit (excluding children) (see Table 8.2.6). This ensured that the researcher interviewed the relevant person, and allowed comparisons in terms of recall between those discussions which the HV held with one person and discussions between the HV and two or more persons. Data were missing for two visits.

Table 8.2.6: People present at the visit of the health visitor

People present at the visit of the HV	Number of visits	Percentage of total*
Mother alone	110	74.8%
Mother and partner	18	12.2%
Mother, partner and grandparent	4	2.7%
Partner alone	1	0.7%
Mother and relative(s)	10	6.8%
Mother, sister and friend	1	0.7%
Mother and friend	3	2.0%
Total	**n =147**	**100%**

* = Percentage discrepancies from 100% are due to rounding of individual percentages

In three quarters (75.5%) of the home visits the HV talked with the mother or partner alone. Watson (1981) also observed the majority of home visits involved the mother and HV alone.

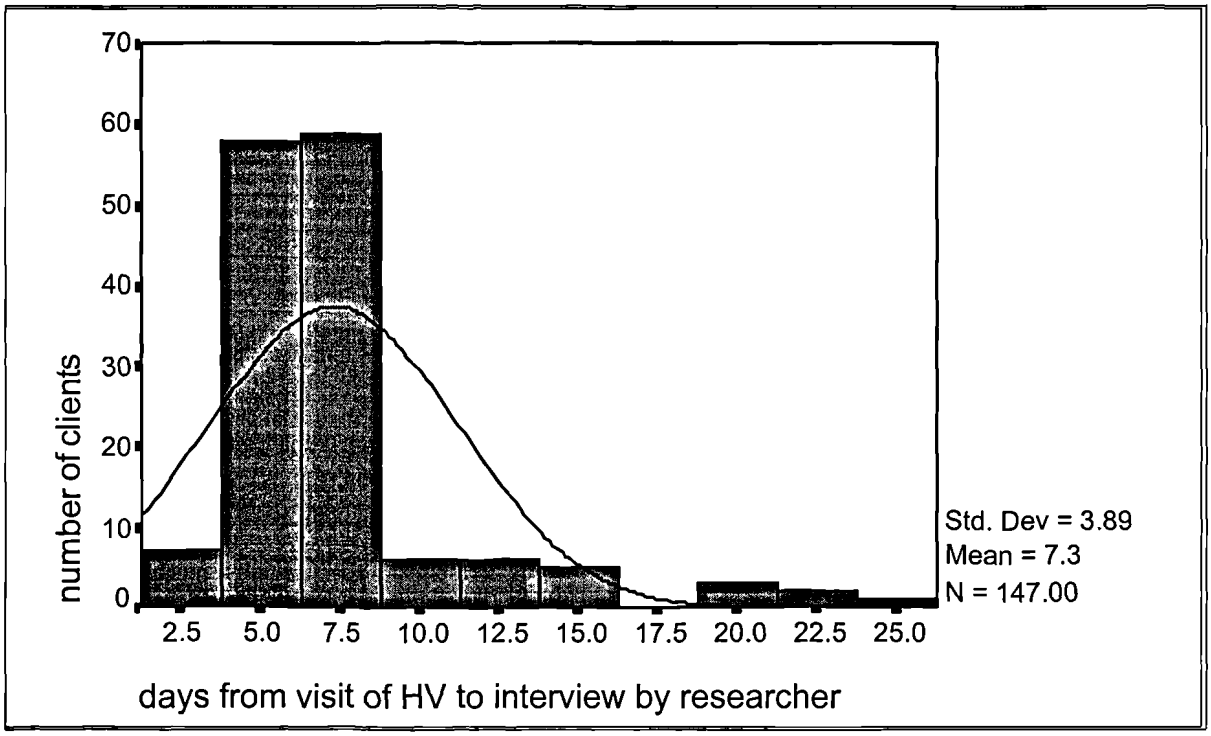
Over two thirds of the mothers (n = 16, 69.6%) in the *not* seen group talked to the HV alone. A further five visits (21.7%) involved the mother and her partner. One client was seen with a friend acting as an interpreter and the final mother was accompanied by a relative.

8.2.7 Number of days from visit of health visitor to interview with researcher

The number of days from the visit of the HV to the subsequent interview between researcher and client was recorded (see Figure 8.2.2), to allow investigation of whether the

amount of time between the two visits made any difference on the subsequent recall by the client. Data were not available for two visits.

Figure 8.2.2: Number of days from visit of health visitor to interview with researcher

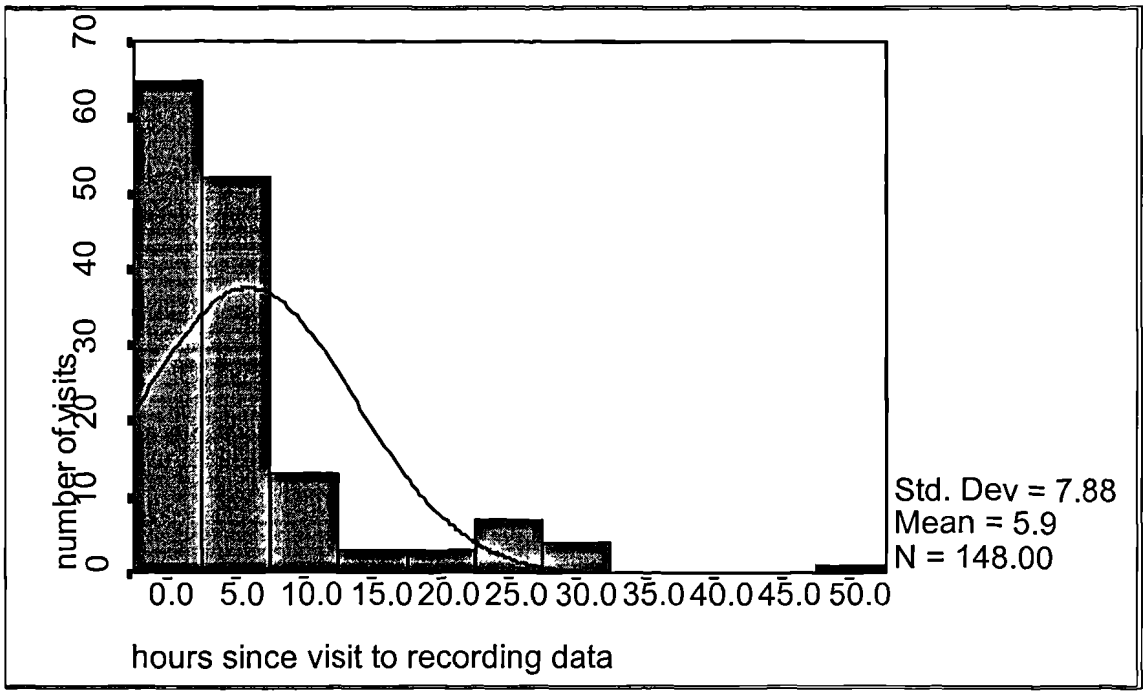


The mean number of days from the visit of the HV to the interview with researcher was 7.34 days (SD 3.894), range 22 days (2 - 24 days). Examination of the histogram shows that the data were not normally distributed. Seventy four per cent of the sample (n = 110) were interviewed by the researcher during the first seven days following the visit to the client by the HV.

8.2.8 Number of hours between visit and completion of the home visit questionnaire

The HVs recorded the number of hours between finishing each visit and entering the data on their interview questionnaire (see Figure 8.2.3). Data were not available for one visit.

Figure 8.2.3: The number of hours between visit and completion of the home visit questionnaire



The mean number of hours from end of visit to completion of the home visit questionnaire was 5.9 hours (SD 7.88), range 50 hours (0 - 50 hours). Examination of the histogram shows that the data were not normally distributed. Over three quarters (n = 113, 76.4%,) of the home visit questionnaires were completed within six hours of the visit.

8.2.9 Visits types

Some home visits were mandatory for the HV, being part of local health visiting protocols. These were first visits to mothers with new babies (primary visits), assessment visits (developmental assessments and clients who had transferred to the HV's caseload). The third group comprised visits which either the HV, the client or both parties had instigated. This group was categorised very generally as issue visits, as theoretically, the visits could have included all age groups and many different issues. However, the majority of issue visits in fact involved discussion of child health or maternal health issues with women with children under five years of age. The visit types are shown in Table 8.2.7.

Table 8.2.7: Visit type - seen group

Visit type	Numbers	Percentage of total
Issue	90	60.4%
Primary	37	24.8%
Assessment	22	14.8%
Total	**149**	**100%**

For the *not* seen group the visit types were roughly comparable with those seen (see Table 8.2.8).

Table 8.2.8: Visit type - not seen group

Visit type	Numbers	Percentage of total
Issue	12	52.2%
Primary	6	26.1%
Assessment	5	21.7%
Total	**23**	**100%**

Summary

The mean age of clients seen during the home visit was 27 years. Most clients were living either with a partner or relative. The sample showed a high rate of unemployment, with 27% of the sample comprising households where no one was employed. Over a third (37.6%) of the mothers had one child, a similar number (38.3%) had two children and just over a fifth (20.8%) had three or more children. In most home visits (75.5%) the HV spoke to either the mother or partner alone.

Few (7.4%) home visits took half an hour or less, with nearly a quarter (23.5%) taking 60 minutes or longer. The mean number of hours between the visit by the HV and her completion of the questionnaire was 5.9 hours. The mean number of days from the HV's visit to the researcher's visit was 7.34 days.

Just under a quarter (24.8%) of home visits were first visits to mothers with new babies. A smaller number (14.8%) were in response to the client transferring onto the HV's workload or to carry out developmental assessments. The remaining (60.4%) visits were nearly all involved with a child health or maternal issue with women with children under five years old.

Comparisons with the characteristics of those clients who were *not* interviewed by the researcher showed little apparent difference between the groups apart from the higher rate of unemployment among those *not* seen.

Section 8.3 Health visitor descriptions of issues discussed during the visit

This section describes data collected by HVs regarding the content of discussions held with clients on each visit. This allowed comparison with the client's accounts of the content of home visits. The HVs recorded all issues discussed with the client and who initiated the discussion of each issue.

8.3.1 Definitions of topics and categories

Nine hundred and ten issues were listed by HVs over 149 visits. Many of these issues could be grouped under the same heading. For example, there were several discussions about behaviour problems which covered *different* types of behaviour such as limited attention span, running away, aggressive episodes. These different issues were all subsumed under a *general topic* heading of "behaviour" to facilitate organisation and analysis of the data from the 149 discussions.

The 910 issues were divided into 71 different topic areas and these were then collapsed into eight categories. A definition is provided for each category in Figure 8.3.1.

Figure 8.3.1: Definitions of categories (home visit)

Feeding
Definition: any issue concerning nutrition irrespective of the age of child includes - breastfeeding 'weaning', bottle feeding, nutrition of older children.
Management of child
Definition: behavioural issues, management of child care e.g. sterilisation of equipment, management of conditions e.g. crying, colic, includes health promotion advice, such as dental advice.
Development of child
Definition: includes formal developmental assessments, enquiries about development or progress of child, - includes speech and vision testing.
Maternal
Definition: issues of a physical or emotional or social nature.
Illness/minor ailments of the child
Definition: includes advice about management of illness, progress of illness or chronic condition, assessment of child's condition.
Immunisation
Definition: includes advice/information about immunisation programmes contraindications for having immunisations, discussion of the benefits and hazards of vaccines.
Services - information about health or social provision for family
Definition: includes child health appointments, nursery provision, access to GP services.
Others
Definition: includes topics concerned with people other than mother and children, e.g. partner, grandparents and rest of family network.

8.3.2 Description of all topics and who raised the issues

The data were organised by grouping the issues discussed under topic headings and then sorting these topics into the relevant categories. In addition it was noted how many times discussion of an issue within a particular topic was raised either by the HV or by the client. The results are given below in Table 8.3.1 which is reported below. Data were not always available for who had raised the discussion and this is shown in the missing data column.

Table 8.3.1: Description of all topics and who raised the topic (home visit)

Category - Maternal				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Mothers' physical health	69	45	15	9
Mothers' mental health	54	37	11	6
Family planning	24	16	7	1
Labour	12	7	5	0
Post natal exam	12	11	1	0
EPND scale*	9	9	0	0
Ante natal advice	7	2	5	0
Housing	7	3	4	0
Bereavement	5	3	2	0
Child care arrangements	3	2	1	0
Employment	3	1	2	0
Post natal depression	3	1	2	0
Post natal exercise	3	3	0	0
Smoking	2	1	1	0
Finances	2	0	2	0
Total number of issues	**215**	**141**	**58**	**16**

* EPND = Edinburgh postnatal depression scale

Category - Management of child				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Behaviour	29	18	9	2
Sibling rivalry	23	17	5	1
Cot death advice	22	20	1	1
Safety	20	16	4	0
Child health management	16	6	8	2
Sleep	15	12	3	0
School/nursery preparation	13	4	8	1
Dental hygiene	9	8	1	0
Routines	6	3	3	0
Toilet training	5	2	3	0
Skin care	5	4	1	0
Sterilisation of equipment	4	4	0	0
Stimulation	4	3	1	0
Enuresis	3	0	3	0
Sun protection	3	3	0	0
Crying	2	1	1	0
Temperature control	2	2	0	0
Handling baby	1	1	0	0
Toxocariasis	1	1	0	0
Total number of issues	**183**	**125**	**51**	**7**

Category - Feeding				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Diet	88	64	17	7
Breastfeeding	21	16	2	3
Total number of issues	**109**	**80**	**19**	**10**

Category - Services				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Parent held records	22	20	1	1
Discussion re. referral	21	14	7	0
Clinics	20	17	2	1
Child health promotion programme	17	16	0	1
Groups	17	13	3	1
HV role	15	12	2	1
6/52 developmental assessment	11	11	0	0
Appointment details	6	6	0	0
Child protection role of the HV	2	0	2	0
Nursery nurse referral	2	1	0	1
Social services	2	2	0	0
Total number of issues	**135**	**112**	**17**	**6**

Category - Development of child				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Progress of child	57	46	8	3
Speech	22	16	5	1
Hearing test	12	8	3	1
2 yr. assessment	10	10	0	0
Child health development	7	5	2	0
Sibling development	6	2	4	0
Skin development	6	1	4	1
Weight development	6	3	3	0
Growth	3	3	0	0
Vision/hearing	3	2	1	0
7/12 developmental assessment	1	1	0	0
Explaining percentile charts	1	1	0	0
Total number of issues	**134**	**98**	**30**	**6**

Category - Illness/minor ailments of the child				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Child health problems	17	7	8	2
Illness advice	14	3	8	3
Skin problems	11	2	9	0
Weight problems	6	5	1	0
Sibling health problems	4	1	3	0
Explanation of illness	1	0	1	0
Total number of issues	**53**	**18**	**30**	**5**

Category - Immunisation				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Immunisation	53	46	3	4
Total number of issues	**53**	**46**	**3**	**4**

Category - Others				
Topic	**Number of times recorded by HV**	**Raised by HV**	**Raised by client**	**Missing data**
Family health	11	10	0	1
Family relationship	10	5	5	0
Relatives health	6	3	3	0
Family leisure	1	1	0	0
Total number of issues	**28**	**19**	**8**	**1**

Overview of recorded issues

The HVs recorded a total of 910 issues discussed with clients during 149 home visits. Fifty eight percent (n = 532) of these issues were concerned with children, 23.6% (n = 215) were focused on maternal well-being and 17.9% (n = 163) were not concerned primarily with either a child or the mother. The wide range of issues reflects Clark's (1973) earlier findings and contrasts with studies which provide minimal detail of issues discussed (Moss et al., 1986, Colliety, 1989). The current study confirms other reports which suggest that issues are not confined to issues concerning children (e.g. Quine and Povey, 1993).

8.3.4 Initiation of topics

Over two thirds (70.2%) of all issues were raised by the HV and just under a quarter (23.7%) by the client. There was some variation in the proportion of issues initiated by the HV or the client according to category type (see Table 8.3.2). The initiation of six per cent (n = 55) of issues was not recorded.

Table 8.3.2: Number of issues discussed and who initiated issues discussed within each category (home visit)

Category	Number of issues	Initiated by HV	Percentage of total	Initiated by client	Percentage of total
Maternal	215	141	65.6%	58	27.0%
Management	183	125	68.3%	51	27.9%
Services	135	112	83.7%	17	12.6%
Development	134	98	73.1%	30	22.4%
Feeding	109	80	73.4%	19	17.4%
Illness	53	18	34. %	30	56.6%
Immunisation	53	46	86.8%	3	5.7%
Others	28	19	67.9%	8	28.6%
Total	**910**	**639**	**70.3%**	**216**	**23.7%**

Clients were most likely to raise issues when they concerned aspects of illness and a child. Immunisation was the category where issues were least likely to be raised by the client. The HVs in the current study reported initiating more issues (70%) than HVs in an earlier study, who recorded the figure of 60% (Clark, 1973).

Summary

A total of 910 issues discussed between client and health visitor were divided into 71 different topic areas. These were then collapsed into the following eight categories: feeding; management of child; development of child; maternal; illness/minor ailments of the child; service - information about health or social provision for family, and immunisations. Over two thirds (70.3%) of all issues were raised by the HV and just under a quarter (23.7%) were raised by the client.

Section 8.4 Client descriptions of issues discussed with the health visitor during the visit

The researcher questioned clients about the HV's visit, including questions regarding advice/information they might have received from the HV.

8.4.1 Client's reports of advice/information given during visit

All clients were asked whether they received any advice or information from the HV, 141 (95%) responded "yes" and eight (5%) responded "no". In those visits where clients did not recall receiving any advice/information HVs reported discussing between 2 and 10 issues. Further description of these participants is provided in Chapter 9.5.

Those who recalled having advice/information from the HV were asked a series of questions about their discussion (see Tables 8.4.1 - 8.4.5).

8.4.2 Most important topic

One hundred and forty one clients identified in their own words the most important issue they discussed with the HV. The issues described were organised under 39 different topics (see Table 8.4.1).

Table 8.4.1: Most important topic (home visit)

Category - Management of child (n = 27)	**Selected by clients**	**Percentage***
Behaviour	6	4.3%
Child health management	5	3.5%
Sleep	6	4.3%
Cot death advice	3	2.1%
Sterilisation of equipment	2	1.4%
Crying	1	0.7%
Enuresis	1	0.7%
Safety	1	0.7%
Skin care	1	0.7%
Toilet training	1	0.7%
		19.1%
Category - Feeding (n = 25)		
Diet	21	14.9%
Breastfeeding	4	2.8%
		17.7%
Category - Maternal (n = 25)		
Maternal mental health	8	5.7%
Maternal physical health	5	3.5%
Family planning	4	2.8%
Housing	2	1.4%
Post natal depression	2	1.4%
Bereavement	3	2.1%
Edinburgh postnatal depression scale	1	0.7%
		17.7%
Category - Development of child (n = 23)		
Speech	8	5.7%
Hearing test	4	2.8%
Weight development	4	2.8%
Progress	4	2.8%
2 yr assessment	2	1.4%
Child health development	1	0.7%
		16.3%

Category - Services (n = 17)		
Child health promotion services	6	4.3%
Groups	5	3.5%
Discussion regarding referral	1	0.7%
Records	2	1.4%
Education/nursery preparation	2	1.4%
HV role	1	0.7%
		12.1%
Category - Illness/minor ailments of child (n = 13)		
Child health problems	3	2.1%
Explanation of illness	2	1.4%
Illness advice	2	1.4%
Sibling health problems	2	1.4%
Skin problems	2	1.4%
Weight problems	2	1.4%
		9.2%
Category - Immunisation (n = 11)		
Immunisation	11	7.8%
		7.8%
Total number of issues	**141**	**100%**

* = Percentage discrepancies from 100% are due to rounding individual percentages

In 99 (70.2%) discussions, the most important topic was concerned directly with care or health of a child. A minority (17.7%) described issues in topic areas which focused on their own well-being. The remaining 12% of topics included information about services for children or for the client but the majority of these involved information regarding services for children.

Issues described as the most important by the client covered seven of the possible eight categories. Issues described by topics from the "others" category were never described as the most important.

8.4.3 Most important category according to visit type

Categories were examined according to the three different visit types (see Section 8.2.9) to explore whether issues from topic areas in *different* categories were chosen as important during different visit types.

Groups appeared to differ between the three types of visit, in the categories from which issues were viewed as most important (see Table 8.4.2). The percentage of times issues in

topic areas from a particular category were chosen compared to the total number of visits in each visit type, is shown in parentheses.

Table 8.4.2: Most important category according to visit type

Category	Number of each visit type (% of total visits)			
	Assessment	**Primary**	**Issue**	**Total**
Management	4 (20%)	6 (18%)	17 (20%)	27
Feeding	5 (25%)	5 (15%)	15 (17%)	25
Maternal	0 (0%)	2 (6%)	23 (26%)	25
Development	7 (35%)	2 (6%)	14 (16%)	23
Services	2 (10%)	10 (29%)	5 (6%)	17
Illness	2 (10%)	2 (6%)	9 (10%)	13
Immunisation	0 (0%)	7 (21%)	4 (5%)	11
Total	**20 (100%)**	**34 (100%)***	**87 (100%)**	**141**

* = Percentage discrepancies from 100% are due to rounding individual percentages

In the assessment visit group, the majority of topics arose in categories concerned with development, feeding and management with a few in services and illness categories. No client chose issues from topic areas in the maternal or immunisation categories.

In primary visits, issues from topic areas in the service and immunisations categories were the most frequently selected. Maternal and development categories were least often chosen.

The main difference between the issue visits and the previous two visit types was the increase in discussion of issues from topic areas in the maternal category, which were selected as most important by almost a quarter of this group. Most maternal health issues discussed were about depression and coping strategies for depression.

8.4.4 Clients' descriptions of advice/information

All 141 clients who identified an issue they had discussed with the HV were asked whether they could recall what the HV had said. All 141 clients were able to describe the discussion.

8.4.5 Clients' reports of prior knowledge

Clients who recalled a discussion were asked whether the advice/information that they had received from the HV was already known to them (see Table 8.4.3).

Table 8.4.3: Did the client report already knowing advice/information?

Previous knowledge of topic discussed	Number	Percentage of total
Clients who reported knowing *all* the information	28	19.9%
Clients who reported knowing *some* of the information	57	40.4%
Clients who reported knowing *none* of the information	36	25.5%
Discussions about referral	12	9.2%
Discussions about mother's feelings	8	5.0%
Total	**141**	**100%**

In twelve cases the discussion concerned a referral to another agency (e.g. speech therapy, housing) about a health or social problem *known* to the mother. A further eight conversations between HVs and mothers had involved exploration of the client's *feelings*. All these responses are described in more detail in Chapter 9.

A quarter of the sample reported that *all* the advice/information received from the HV was new advice/information. A further two fifths received *some* new advice/information. Just under a fifth of the sample knew *all* the advice/information given, which raises questions about the relevance of the discussion with the HV.

In order to explore these points, when clients said they knew all or some of the information they were asked *why* they discussed the issue. These qualitative data are presented in Chapter 9.

8.4.6 Comparisons between data provided by the client and data provided by the health visitor

Clients were asked to describe *all* the issues they remembered discussing during the HV's last visit. This list of issues was compared with the number of times issues were recorded by the HV. These issues were subsumed into topics as described previously (see Section 8.3.1). It was then possible to identify the topics that were *not* recalled by clients. In addition, the number of times each issue was recalled by the client as a percentage of the number of times recorded by the HV was noted. (see Table 8.4.4).

Table 8.4.4: Recall of topics by clients

Category – Maternal			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Mothers physical health	69 (32.1%)	17 (23.6%)	(24.6%)
Mothers mental health	54 (25.1%)	30 (41.7%)	(55.6%)
Family planning	24 (11.2%)	7 (9.7%)	(29.2%)
Labour	12 (5.6%)	1 (1.4%)	(8.3%)
Post natal examination	12 (5.6%)	0 (0%)	(0%)
EPND scale*	9 (4.2%)	5 (6.9%)	(55.6%)
Ante natal advice	7 (3.3%)	2 (2.8%)	(28.6%)
Housing	7 (3.3%)	4 (5.6%)	(57.1%)
Bereavement	5 (2.3%)	3 (4.2%)	(60%)
Child care arrangements	3 (1.4%)	1 (1.4%)	(33.3%)
Employment	3 (1.4%)	0 (0%)	(0%)
Post natal exercise	3 (1.4%)	0 (0%)	(0%)
Post natal depression	3 (1.4%)	2 (2.8%)	(66.7%)
Smoking	2 (0.9%)	0 (0%)	(0%)
Finances	2 (0.9%)	0 (0%)	(0%)
Total number of issues	**215 (100%)**	**72 (100%)**	

* EPND = Edinburgh postnatal depression scale

Category - Management of child			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Behaviour	29 (15.8%)	16 (18.8%)	(55.2%)
Cot death advice	22 (12.0%)	10 (11.8%)	(45.2%)
Sibling rivalry	23 (12.6%)	8 (9.4%)	(34.8%)
Safety	20 (10.9%)	6 (7.1%)	(30.%)
Child health management	16 (8.7%)	13 (15.3%)	(81.3%)
Sleep	15 (8.2%)	8 (9.4%)	(53.3%)
Education/nursery preparation	13 (7.1%)	4 (4.7%)	(30.8%)
Dental hygiene	9 (4.9%)	1 (1.2%)	(11.1%)
Routines	6 (3.3%)	5 (5.9%)	(83.3%)
Toilet training	5 (2.7%)	3 (3.5%)	(60%)
Skin care	5 (2.7%)	5 (5.9%)	(100%)
Sterilisation of equipment	4 (2.2%)	2 (2.4%)	(50%)
Stimulation	4 (2.2%)	0 (0%)	(0%)
Enuresis	3 (1.6%)	1 (1.2%)	(33.3%)
Sun protection	3 (1.6%)	1 (1.2%)	(33.3%)
Crying	2 (1.1%)	1 (1.2 %)	(50 %)
Temperature control	2 (1.1%)	1 (1.2 %)	(50 %)
Handling baby	1 (0.5%)	0 (0%)	(0%)
Toxocariasis	1 (0.5%)	0 (0%)	(0%)
Total number of issues	**183 (100%)**	**85 (100%)**	

Category - Services			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Parent held records	22 (16.3%)	8 (15.1%)	(36.4%)
Discussion re. referral	21 (15.6%)	11 (20.8%)	(52.4%)
Clinics	20 (14.8%)	8 (15.1%)	(40%)
Child health promotion programme	17 (12.6%)	9 (17.0%)	(50%)
Groups	17 (12.6%)	9 (17.0%)	(52.9%)
HV role	15 (11.1%)	2 (3.8%)	(13.3%)
6/52 developmental assessment	11 (8.1%)	1 (1.9%)	(9.1%)
Appointment details	6 (4.4%)	3 (5.7%)	(50%)
Child protection role of the HV	2 (1.5%)	1 (1.9%)	(50%)
Nursery nurse referral	2 (1.5%)	0 (0%)	(0%)
Social services	2 (1.5%)	0 (0%)	(0%)
Total number of issues	**135 (100%)**	**53 (100%)**	

Category - Development of child			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Progress of child	57 (42.5%)	27 (31.4%)	(47.4%)
Speech	22 (16.4%)	12 (14.0%)	(54.5%)
Hearing test	12 (9.0%)	10 (11.6%)	(83.3%)
2 yr assessment	10 (7.5%)	10 (11.6%)	(100%)
Child health development	7 (5.2%)	7 (8.1%)	(100%)
Sibling development	6 (4.5%)	5 (5.8%)	(83.3%)
Skin development	6 (4.5%)	5 (5.8%)	(83.3%)
Weight development	6 (4.5%)	6 (7.0%)	(100%)
Growth	3 (2.2%)	3 (3.5%)	(100%)
Vision/hearing	3 (2.2%)	0 (0%)	(0%)
7/12 developmental assessment	1(0.7%)	1 (1.2%)	(100%)
Explaining percentile charts	1(0.7%)	0 (100%)	(100%)
Total number of issues	**134 (100%)**	**86 (100%)**	

Category - Feeding			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Diet	88 (80.7%)	57 (78.1%)	(64.8%)
Breastfeeding	21 (19.3%)	16 (21.9%)	(76.2%)
Total number of issues	**109 (100%)**	**73 (100%)**	

Category - Illness/minor ailments of the child			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Child health problems	17(32.1%)	11 (29.7%)	(64.7%)
Illness advice	14 (26.4%)	11 (29.7%)	(78.6%)
Skin problems	11(20.8%)	6 (16.2%)	(54.5%)
Weight problems	6 (11.3%)	5 (13.5%)	(83.3%)
Sibling health problems	4 (7.5%)	3 (8.1%)	(75%)
Explanation of illness	1 (1.9%)	1 (2.7%)	(100%)
Total number of issues	**53 (100%)**	**37 (100%)**	

Category - Immunisations			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Immunisations	53 (100%)	28 (100%)	(52.8%)
Total number of issues	**53 (100%)**	**28 (100%)**	

Category - Others			
Topic	**Number of times recorded by HV**	**Number of times recalled by client**	**Frequency recalled by client as % of times recorded**
Family health	11(39.3%)	2 (20%)	(18.2%)
Family relationship	10 (35.7%)	6 (60%)	(60%)
Relatives health	8 (28.6%)	2 (20%)	(28%)
Family leisure	1 (3.6%)	0 (0%)	(0%)
Total number of issues	**28 (100%)**	**10 (100%)**	

Mothers recalled 444 of the issues recorded by the HV. There appeared to be a difference in the percentage of issues recalled according to the category type. In three categories (feeding, issues, development of the child, and illness/minor ailments of the child) clients apparently recalled approximately two thirds of issues recorded by the health visitor. The

immunisation category was recalled by just over half of the clients. The remaining four categories revealed a range of between one third and over two fifths of issues recalled, with issues in the maternal category apparently least likely to be recalled.

8.4.7 Issues recalled by client but not recorded by the health visitor

Forty three clients (28.9%) described a total of 52 issues which the HV had not recorded. These issues were subsumed into topics as noted previously (see Section 8.3.1) which are shown in Table 8.4.5.

Table 8.4.5: Recall by clients of topics not recorded by the health visitor

Topic	Number of times noted by client
Category - Management of child	
Sleep	4
Cot death advice	3
Child health management (colic)	3
Dental hygiene	2
Behaviour	1
Sibling behaviour	1
Skin care	2
Toilet training	1
Use of dummy	1
Subtotal	**18**
Services	
Clinics	3
Appointment details	2
Group/support measures	1
6/52 appointment	1
Discussion re. Referral	2
Subtotal	**9**
Immunisation	
Immunisation	8
Subtotal	**8**
Category - Development of child	
Speech	2
Progress of child	2
Explanation of phenylketenuria screening	1
Subtotal	**5**
Category - Illness/minor ailments of the child	
Skin problems	3
Child health problems	1
Sibling skin problems	1
Subtotal	**5**
Category - Maternal issues	
Family planning	4
Subtotal	**4**
Category - Feeding issues	
Diet	3
Subtotal	**3**
Total	**52**

A third (n = 18) of issues reported by the client but not recorded by the HV was concerned with management of the child. Clients noted between three and nine issues in six further categories (illnesses/minor ailments of the child; development of the child; maternal issues; immunisations; services).

It has been noted previously (see Section 8.3) that HVs recorded a total of 910 issues. Forty three clients mentioned a further 52 issues. Examination of recall of issues by clients might be based on one of two possible totals: the 910 issues recorded by the HV or 910 plus the *further* 52 issues (n = 962) mentioned by the client.

Two main explanations might account for the client recalling issues not recorded by the HV. First, the HV may have misrecorded some issues. Second, the client may have made a mistake in recalling issues. However, it should be noted that issues described by clients but not recorded by HV constitute only 5.7% of the total issues recorded. The researcher used the former figure of 910 for the subsequent statistical tests as discussed in Chapter 4.12.

Summary

Most (94.6%) clients recalled discussing an issue with the HV. In terms of prior knowledge just over a quarter (25.5%) of the respondents stated that the advice/information received was new while a further two fifths (40.4%) received *some* new advice/information.

The majority of clients (71.6%) selected issues concerned with feeding, management of their child, maternal issues, development of their child, as the most important topics discussed. Mothers receiving primary visits appeared most likely to mention topics concerned with services, whilst clients in the assessment visit group selected developmental issues. By contrast, mothers in the issues group were most likely to describe issues concerning their own health or social concerns.

The proportion of all issues recalled by clients varied between a third and two thirds according to the type of category. In addition, it was observed that 52 issues were mentioned by clients but not recorded by the HV.

Section 8.5 Examination of the relationship between client and visit variables on the recall of information

As identified earlier (see Section 8.4.6) clients were asked to recall all issues discussed with the HV. This section of the chapter reports the results of parametric and non-

parametric statistical analyses carried out to explore differences and similarities between subgroups within the sample in terms of the proportion of issues recalled.

8.5.1 Recall of all issues

The number of issues discussed on visits ranged between 1 and 15, with a mean of six per visit. The following variables were examined with regard to any relationship with the proportion of issues recalled by clients: number of topics discussed; age of client; number of children; length of visit; days from the HVs visit to research interview; employment status of household; whether mother was seen by the HV alone; and type of visit. In addition, number of hours between the end of the visit by the HV and her completion of the questionnaire was examined with regard to any possible association with the number of issues mentioned by the client but *not* recorded as discussed by the HV (see Table 8.5.1, 8.5.2).

Table 8.5.1: Correlations with proportion of issues recalled (home visits)

Variable	n	Correlation coefficient	df	significance
Age of client	147	r = 0.1474	145	p = 0.075 (NS)
Number of issues discussed	149	tau = -0.2665	-	p = 0.000
Number of children	149	tau = -0.0865	-	p = 0.178 (NS)
Days from HV visit to research interview	147	tau = 0.0260	-	p = 0.670 (NS)
Length of visit	148	tau = -0.0512	-	p = 0.446 (NS)

Table 8.5.2: Correlation between issues mentioned by the client but not recorded by the health visitor and hours from visit to health visitor completing questionnaire

Variable	n	Correlation coefficient (tau-b)	significance
Hours from visit to HV completing questionnaire	148	tau = 0.1751	p = 0.272 (NS)

There was a low negative correlation between the number of issues recorded by the HV and the proportion of issues recalled by the client.

There was no significant correlation between: the client's age, the number of children a client had, the days from the visit to research interview and length of the visit made by the HV and recall of issues (see Table 8.5.1). In addition, there was no significant correlation

between the number of hours from the end of a visit by the HV to the completion of her questionnaire, and the identification by clients of issues *not* mentioned by the HV (see Table 8.5.2).

Employment of household

The sample was divided into households with at least one person who was working and households where everyone was unemployed. The effect of membership of one or other of these two categories on recall was examined using t-test for independent groups. There was no significant difference between the groups (t = -.94, df 147, p = 0.348 [NS]).

Mothers seen alone or with others

The sample was divided into those who talked with the HV by themselves and those who talked with the HV accompanied by at least one other person. The effect of membership of one or other of these two categories on recall was examined using t-test for independent groups. There was no significant difference between the groups (t = -1.13,df 147, p = 0.261 [NS]).

Visit type

Table 8.5.3: Number of issues given and proportion recalled according to visit type

Visit type	Mean number of issues discussed	Mean proportion of issues recalled by clients
Primary visits	9	34 %
Assessment visits	7	45 %
Issue visits	5	52 %

Comparison between visit types

Of the total number of issues discussed, the proportion of issues recalled by clients was examined, using one way analysis of variance.

There was a significant difference in the proportion of issues *recalled*, according to whether the client was visited as a primary visit, assessment visit or issue visit (F = 9.3868, df = 2, 145, p = 0.001).

Post hoc examination of the groups, using the Bonferroni method to correct for increased risk of type 1 error as a result of multiple comparisons, revealed that the source of the

difference between the groups lay in differences between the primary visit group and the issue visit group ($p < 0.05$), with the issue group recalling more information. There were no significant differences between any other pairs of groups. However, it was thought that the overall amount of information *given* in terms of the number of issues, might affect the proportion recalled. This element was entered into the analysis as a covariate.

The amount of information recorded as *given* by the HV differed according to type of visit ($F = 6.877$, $df = 1$, $p = 0.01$), and its inclusion into the analysis as a covariate resulted in a finding of no significant difference between the proportion of information recalled between the visit types ($F = 2.602$, $df = 2$, $p = 0.078$ [NS]).

A further analysis of amount of information given using the Bonferroni correction showed significantly more information given to primary visit clients than to assessment visit clients and issue visit clients, significant at the 5 per cent level.

Summary

Generally, the association between a number of variables and the proportionate issues recalled by a client from each visit showed no significant differences. Initial examination of the visit type and recall suggested that this might have an effect on client recall. However, further analysis showed that this apparent difference disappeared when the number of issues recorded by the HV as discussed during the visit was included in the analysis.

CHAPTER 9

QUALITATIVE DESCRIPTIONS BY THE CLIENT OF ADVICE/INFORMATION RECEIVED FROM THE HEALTH VISITOR

Section 9.1 Introduction

Chapter 8 described quantitative data resulting from client responses to closed questions. This chapter describes qualitative data that resulted from open questions used to clarify the client's responses to these closed questions. The chapter is divided into four sections covering different aspects of the findings:

- helpfulness and importance of advice/information received by the client
- reasons given by the client for discussions with the health visitor when all or some of the advice/information was known
- use of advice/information by the client and reasons given by clients for *not* using advice/information
- examination of the responses of those clients who reported no recall of their discussion with the health visitor

Brief summaries are provided throughout the chapter.

Section 9.2 The helpfulness and importance of the advice/information to the client

Clients were asked to rate whether it had been helpful and important to have the advice/information and then to explain the nature of any helpfulness/unhelpfulness and importance/unimportance. This provided the opportunity to explore the value or otherwise the mothers attributed to these discussions.

9.2.1 Helpfulness of the advice/information

Clients' responses to a five point attitude scale regarding helpfulness of the advice/information are shown in Table 9.2.1.

Table 9.2.1: Helpfulness of advice/information to client (home visit)

Helpfulness	Number of clients	Percentage**
Very helpful	95	67.4%
Fairly helpful	38	27.0%
Neither helpful nor unhelpful	7	5.0%
Fairly unhelpful	0	0%
Very unhelpful	1	0.7%
Total	**141***	**100%**

* 8 clients did not recall any discussion
**Discrepancies from 100% are due to rounding of individual percentages

Descriptions of helpfulness

The majority of clients (n =133) viewed the advice/information as either very helpful or fairly helpful. There were four main reasons why clients reported the advice/information helpful: it increased the mother's knowledge about an issue, it helped the mother manage a problem, it reassured the mother or it made the mother *feel* better.

Increasing knowledge

Forty clients made referred to additional knowledge they had gained from the HV.

(Client 48)

> *'There's nothing else she could have told me* [about child's development]. *She showed me how to encourage him.'*

(Client 97)

> *'I didn't know how many accidents happen through stupidity.'*

(Client 132)

> '*... some of it was information that I didn't know before so obviously she gave me the information that I needed.'*

Ten of these clients referred to three particular aspects of advice/information from the HV: it was easy to understand (n = 5); it was professional knowledge (n = 3); it was accessible (n = 2).

(Client 24)

'*... when she came and talked to me it made it easier to understand the problem.*'

(Client 121)

'I needed to talk to a health professional about it.'

this mother explained:

'*... I hadn't had chance to speak to anybody properly about it who's actually been there, and sometimes they've been there just a bit, sort of confirmation oh well never mind they do grow out of it, which I had already had, so it was important to me. I think I just felt that Elaine* [HV] *would probably provide a more comprehensive answer than an anecdotal answer.*'

(Client 100)

'*She* [HV] *doesn't seem to hide away from you, she came out* [and did a home visit] *straight away.*'

Helping manage a problem

An equal number of respondents (n = 40) observed that helpfulness of the advice/information was linked with helping the mother cope with a problem.

(Client 1)

'I suppose it convinced me to keep using it [colic preparation].'

(Client 36)

'She was more relaxed, I sort of felt she knew what she was on about and she showed me what to do.'

(Client 141)

'Well I'm always confident with the advice she gives me I never ever take it lightly, whatever I want to know she gives me definite answers or health advice and I always take it and I'm always pleased with it ....'

Reassurance

Just under a quarter (n = 31) of mothers highlighted reassurance that they gained from the advice/information. Reassurance was mentioned explicitly by eight clients:

(Client 62)

'Reassured me, it's so important I want to do everything right ....'

(Client 145)

'It reassured me, that somebody else had had those problems and they'd sorted it out and they knew it worked for them. So it made me feel better that I wasn't the only one who had those problems.'

(Client 87)

'It was reassurance that what I was doing was correct and safe.'

A further six mothers referred to experiencing 'peace of mind' or having their 'mind put at rest' as a result of the discussion:

(Client 5)

'Put my mind at rest and gave me confidence about having the injections.'

(Client 134)

'I needed to know for my own peace of mind, it was good information.'

(Client 139)

'... more than anything else it is just the peace of mind to know that the help is there if you need it, you have got the contacts there. I mean it is such a shock

to your system having a baby and knowing that there is a friendly face there that you can talk to who will give you any advice that you want.'

The remaining 17 mothers described or implied that the advice/information provided reassurance by clarifying issues with the HV.

(Client 37)

'I want to make sure that I was doing the right thing.'

(Client 42)

'*... I sort of knew myself that I should go to the doctors but I just waited to see what Jill* [HV] *said.*'

(Client 57)

'Because well I think it is confusing anyway you have got a lot going through your mind and it was I mean the confusion more than anything was unhelpful it was it was really sort of puzzling us ... to know that they are there if you need them sets you more at ease and I think if you are more at ease anyway it just sort of, everything goes along a bit easier.'

Made mother feel better

The final group of 22 responses included descriptions of how the mother had been feeling prior to the discussion or how she felt as a result of talking with the HV.

(Client 82)

'She made me feel at ease as if she had helped me and I was getting well not panicking but a bit concerned, and she said well I'll bring it forward and tell the nursery as well and I felt like she had taken that load off me and was helping me.'

(Client 86)

'Like I said just sitting listening to me moan really. I felt like she gave me advice when I asked for it, not that she pushed advice, rammed it down my throat like some people do don't they.'

(Client 120)

'It helps me talking to people, it makes me feel better in myself, it gives me a boost.'

Advice/information described as neither helpful nor unhelpful

Seven clients commented that the information was neither helpful nor unhelpful because clients did not receive any new information. In most (n = 6) cases the issue had been introduced by the HV.

(Client 4)

'*She* [HV] *didn't give me anything I didn't know.'*

(Client 40)

'*Well I already knew I mean basically I've done it before.'*

(Client 125)

'I already knew the information.'

The remaining mother had been checking an issue with the HV but appeared to view the advice/information as inadequate.

(Client 67)

'It was old information, there was nothing really new.'

Advice/information described as very unhelpful

One client reported that the advice/information was very unhelpful. This issue was introduced by the HV and provided no new information for the client.

(Client 85)

'It came too late, if she had come earlier or mentioned it at six weeks it would have been useful.'

Summary

The majority (n = 80) of explanations that mothers gave about why the advice/information received from the HV was fairly or very helpful appeared to be of a practical nature. Mothers stated that either they had learned something from the HV (30.1%) or the new knowledge had helped with the management of a problem (30.1%). A smaller number (23.3%) described reassurance arising from the discussion with the HV. The remaining mothers (16.5%) used phrases that suggested that they had felt better as a result of the talking with the HV.

A few (5.3%) mothers reported the advice/information as neither helpful nor unhelpful or very unhelpful. These mothers explained that they already knew the advice/information given.

9.2.3 Importance of information

The question regarding importance of the advice/information to the client sought to examine the emphasis which mother placed on the issue. Clients' responded to a five point attitude scale regarding importance of the advice/information are (Table 9.2.2).

Table 9.2.2: Importance of advice/information to client (home visit)

Level of importance	Numbers	Percentage
Very important	90	63.8%
Fairly important	39	27.7%
Neither important nor unimportant	9	6.4%
Fairly unimportant	3	2.1%
Very unimportant	0	0%
Total	**141***	**100%**

*8 clients did not recall any discussion and therefore were not asked this question.

Descriptions of importance

Most (n =129) clients reported that advice/information was either very important or fairly important. Five explanations of why advice/information was *important* were provided by mothers.

Solved or avoided problems

Most responses (n = 62) from mothers commented on how advice/information had contributed to a health or management issue concerning their child.

(Client 50)

'Well I've been really concerned about John's speech and Carol [HV] *did actually query that he could hear properly and I said I think he can well that was like a question in my mind I wonder if his hearings all right and I want him to progress at the rate he should be doing and I want to find out if there's anything that I can be doing to help him.'*

(Client 77)

'Because without the information [about management of enuresis] *I wouldn't have known.'*

(Client 128)

'It was very important because I was on the verge of giving up [breastfeeding].'

Child's well-being

Thirty one mothers viewed the discussion as important because it involved an aspect of child care. These comments suggested that *anything* concerning their child's care was defined as important.

Sixteen clients supplied simple statements that the issue discussed was important.

(Client 48)

'*Its fairly important to know how to encourage them to come on.*'

(Client 81)

'Its an important issue.'

(Client 92)

'*Diet is important.*'

A further twelve clients made overt reference to their child's welfare.

(Client 38)

'Well any information that you get about your bairn is very important isn't it.'

(Client 114)

'*Because it was to do with Tom* [baby] *he comes first with me so it was important that she told me it was right.*'

(Client 132)

'*Its my son's health.*'

The remaining three clients expressed a need for accumulating as much advice/information as possible in order to provide the best care for their child.

(Client 63)

'*You like all the information and advice that you can get really, its all new to you, you like to know as much as possible.*'

(Client 29)

'*Well just because you want the best for them you know, or trying to do the best for them I think and any help that you can get when you are a first time mum I think is good.*'

(Client 67)

'*Its important* [receiving advice/information] *whether or not you are a first time mother there are things that you could have missed.*'

Mother's feelings

A number of mothers (n =18) linked importance of the discussion to feelings of distress. The apparent implication was that the discussion made them feel better.

(Client 6)

'Because I've been, last week, well before the visit, I was feeling a bit weepy, I cried sometimes there was a couple of days when I just filled up with tears, and I didn't know why, letting things get on top on me and I had no reason to really and then when I sat down and filled this questionnaire in and I thought have been crying in the past week and I filled in yes then when she had gone and I'd been thinking about it things aren't on top of me so I've been thinking of reasons why not to cry and I don't need to.'

(Client 120)

'Sometimes its important to talk, there's more support [from HV] *than from friends and family.'*

(Client 121)

'Because I'd got to desperation point really with it, and even if the things that were suggested didn't work, at least it gave me another chink of light that might stop the crying for a period of time.'

Reassurance

Five clients referred to reassurance gained from the HV as important.

(Client 126)

'It's reassurance to get someone's opinion the same as yours.'

(Client 26)

'... I really needed reassurance that it was still okay.'

(Client 54)

'The reassurance is very important.'

A further four clients used a phrase associated with reassurance:

(Client 5)

'It put my mind put at rest.'

In addition, two mothers described the importance of having their actions verified by the HV in a way which suggested reassurance.

(Client 53)

'... I'm insecure as a mother when they are ill .... Its just important that she makes you feel that you are doing the right thing, you are not doing the wrong thing.'

(Client 7)

'Its common sense really but if you ask you know you are doing the right thing.'

Educational progress of the child

Seven mothers reported the issue discussed (either hearing or speech problems) as potentially affecting their child's educational opportunities.

(Client 82)

'Yes [it was important], *Steven's schoolwork ... I felt that his concentration was drifting because he couldn't hear his teachers.'*

(Client 109)

'When he goes to nursery I want him to be understood.'

(Client 107)

'It was to me [important] *because when people don't understand him he gets bad tempered, they are not understanding him at the nursery and he is getting bad tempered.'*

Advice/information described as neither important nor unimportant

Nine clients commented that the information was neither important nor unimportant. Six mothers observed that the issue was of little concern to them.

(Client 138)

'I wasn't really worried, I never thought oh I must see about this.'

(Client 56)

'it was not really a big problem.'

The remaining three mothers knew all or some of the advice/information.

(Client 25)

'I knew most of it, it helped me with things that I didn't know.'

(Client 40)

'I knew the information really.'

Advice/information described as very unimportant

The same reasons were given by three mothers who stated the advice/information was fairly unimportant.

(Client 10)

'By the third baby I've got a bit more confidence.'

[taken from interview notes]

(Client 68)

'I already knew it.'

(Client 71)

'It was only a minor thing, it wasn't serious.'

Summary

The largest group of respondents describing the importance of the advice/information referred to obtaining help with problems (48.1%). A further 5.4% of mothers linked the advice/information with alleviating concerns about possible future educational difficulties because of hearing or speech problems.

Just under a quarter (24.0%) of mothers equated importance of advice/information with the fact that it involved their child. For this group of clients *anything* that might benefit their child's welfare was by definition important. For the remaining respondents the importance apparently lay in the effect of the discussion on the *mother*. Fourteen percent of mothers described feeling better in some way and just over eight per cent (8.5%) of clients referred to being reassured.

Just over nine per cent (9.5%) of respondents reported the advice/information as neither important nor unimportant or very unimportant. Two reasons were given by these mothers either that the issue was trivial or that they already knew the advice/information.

Section 9.3 Reasons for discussion with the health visitor

Eighty five clients were asked *why* they discussed the issue when they said they knew some or all of the information. This question elicited a variety of responses which were subsumed by the researcher under four main responses (see Table 9.3.1. and Table 9.3.2).

Clients who reported knowing all the advice/information

Twenty eight clients reported already knowing *all* the advice/information given by the HV (Table 9.3.1).

Table 9.3.1: Advice/information known - reason for discussion (home visit)

Reason	Number
Checking information	12
HV raised issue	9
Reassurance	7
Total	**28**

Checking

The majority of these respondents (n = 12) used the HV to check information. They checked that a proposed action of the mother's was correct, cross-checked information received from other professionals with the HV, checked that a situation was normal or clarified information by the mother checking her understanding with the HV.

(Client 5)

> *'Well she* [hospital nurse] *did say double check and also I like to check with her, I've got a lot of faith in her. When I was breastfeeding Shelley I had quite a lot of trouble, mastitis and that, and I found her very, very supportive. I found her* [HV] *really good, she's really easy to talk to and any information I've ever asked her she's, always so confident so I wanted to check.'*

(Client 7)

> *'I mean well like in hospital, they always said like you don't have to clean it* [umbilicus] *just maybe give it a little rub now and again. Then when it started popping up a bit that's when I got real concerned see, it should have started drying off but it wasn't, it was like mucky a bit'.*

(Client 67)

> *'It well like when you haven't had a baby for a long time, you sort of like think, it does come back new to you, but she you know, you always think that there must be something that you haven't thought of. So you do tend to look at them as helping, even when you know you have had, it doesn't matter how many kids you have had.'*

Health visitor raised issue

Nine clients said they discussed an issue in response to the HV introducing it. In this group, five mothers reported the information was neither helpful nor unhelpful (n = 4) or very unhelpful (n = 1). In all these cases the explanation was that there was no *new* information. However, four of the mothers although knowing the information described it as fairly helpful because of reassurance arising from confirmation of their understanding about an issue.

(Client 94)

'I already had the information from the antenatal class.'

(Client 144)

'Gives me confidence that everything is okay.'

Reassurance

Six mothers referred to reassurance gained from raising a concern with the HV. The HV confirmed that either there was no problem and/or that the mother was managing the situation appropriately.

(Client 46)

'Reassurance, before she came I was nervous afterwards I felt so much easier.'
[taken from notes]

(Client 143)

'To know that Michael is putting weight on is a real boost he needs to put weight on for his operation, it's really important.'

One client referred to reassurance gained from the HV affirming the child's developmental progress.

(Client 149)

'I am not an expert. I can only do so much there is no one else to ask we don't see many children to compare her with.'

Discussions about referrals and about the mother's feelings

In the preceding descriptions of mothers who knew the information it has been noted that in the majority of cases the fact that mothers knew the subsequent information given in response to a question did not imply a lack of value in asking the question or an inappropriate response by the HV.

In a further 20 (see Table 8.4.3) responses mothers could also be described as *knowing* the information. Twelve mothers talked with the HV about a referral to another agency. Generally, these health or social problems were known to the mothers who were involved in the referral process *with* the HV. In three cases the mother was informing the HV about the *outcome* of a referral.

(Client 142)

> '*She* [daughter] *had had a hearing test which I wanted to discuss with her* [HV].'

(Client 82)

> '*She* [HV] *said she would get the appointment quicker, and she rang the nursery to tell them the problem.*'

The remaining eight mothers selected discussions about *their* feelings as the most important aspect of the visit.

(Client 135)

> '*She* [HV] *listened, I felt I was getting listened to and it was my feelings and what it did to me.*'

Clients who reported knowing some of the advice/information

Fifty seven clients reported already knowing *some* of the advice/information given to them by the HV (see Table 9.3.2).

Table 9.3.2: Some advice/information known - reason for discussion (home visit)

Reason	Number
Checking information	21
To get more information	19
HV raised issue	12
Reassurance	5
Total	**57**

Most mothers were again checking information or seeking reassurance that all was well regarding some aspect of child care or health. This was similar to in the 'knew *all*

information' group. Clients who knew all the advice/information and clients who knew some of the advice/information gave the same reasons for their discussion with one exception. Nineteen clients in the 'knew some' group reported discussing an issue to get *more* information.

To get more information

All 19 clients described receiving additional information from the HV. Seven had used the information and a further 10 intended to use the information in the future. The remaining two mothers received *explanation* about a forthcoming operation for one mother and a child's medical condition for the second.

(Client 76)

> *'Contraception is not something I know a great deal about, hence the pregnancy in the first place, I knew some of the information, I heard some of it from the midwife but she didn't have all the information and she suggested the health visitor.'*

(Client 48)

> *'I knew tiny bits but I didn't really know at what age they progress. As she was doing every exercise she said around about what age they started doing things and how we could help them and just helped me understand a lot more.'*

(Client 49)

> *'With her* [the baby] *being anaemic, I had to tell her about the folic acid, the midwife said to have it, and she* [HV] *asked if I understood it, and I said no not really, so she explained it to me.'*

Health visitor raised issue

On twelve occasions clients discussed an issue because the HV raised the issue. Eleven mothers from this group reported this as fairly or very helpful and fairly or very important and either had or were intending to use the advice/information.

(Client 73)

'I knew something about it but the new information helped answer things I didn't know.'

(Client 75)

'We know what to do now to avoid cot death.'

One mother stated that the advice/information was helpful but not important as she had already discussed this with her partner. The remaining mother who reported the advice/information was neither helpful nor unhelpful and neither important nor unimportant felt that the additional information she had gained about weaning was trivial and was available in books anyway.

(Client 4)

'Its something that comes naturally its common sense.'

This mother while offering no complaints, observed that she did not feel that the routine visiting she had received was actually necessary for her.

'I do find it sometimes a bit, when she says she's coming and I think well like there's no point to come like, she could go and see somebody else ... that's personal but I suppose they have to [visit] *... they sometimes don't give you anything out of it or anything you need.'*

Summary

Two fifths (60.0%) of mothers reported knowing all or some of the information. Generally, this did not reflect dissatisfaction as shown by the accompanying helpfulness and importance scores and the explanations for the discussion. Most mothers were using the HV to check or clarify issues or seeking reassurance on some issue. This did not necessarily require new knowledge for the mother's enquiry to be satisfied.

However, some of the group who discussed issues because the HV raised them appeared less satisfied. Four mothers who knew all the information given by the HV reported

favourable comments about their discussion but others (n = 5) gave neutral or negative helpfulness and importance scores. By contrast, when mothers reported only knowing *some* of the advice/information initiated by the HV most (n = 11) clients rated it fairly or very helpful or fairly or very important.

An additional 14.1% of mothers discussed referrals about a health or social problem or a psychological or emotional issue. These mothers talked about the progress or treatment of their child or were arranging with the HV about a referral. Clients who discussed feelings were telling HVs how *they* felt. Clients knew the content of these discussions because of the personal nature of the issue or because it was an established medical or social situation about which they were conferring with the HV.

Section 9.4 Use of advice/information

All respondents were asked whether they had *used* the advice or information given by the HV and the responses are shown in Table 9.4.1.

Table 9.4.1: Use of advice/information (home visit)

Use of advice/information	Number of clients	Percentage**
Had/would use	83	58.7%
Reassurance	17	12.1%
Explanation	8	5.7%
Referrals	12	8.5%
Discussion of feelings	8	5.7%
Would not use	6	4.3%
Have used some information	5	3.5%
Not sure	2	1.4%
Total	**141***	**100%**

* 8 clients did not recall any discussion and therefore were not asked this question.
**Percentage discrepancies from 100% are due to rounding up of individual percentages

Clients who would not use the advice/information

Five of the six mothers knew the advice/information given by the HV (who had not established the client's need for discussion). In these instances the advice/information was apparently redundant.

(Client 10)

'Because like what I say with it being my third baby I just knew what was right.'

[taken from interview notes]

(Client no 40)

'Basically I've done it all before.'

The remaining mother had welcomed the discussion with the HV but changed her mind about following the advice/information because circumstances had changed.

(Client 42)

'Even though Sue [HV] *said go back, but I'm not going to because I feel okay now.'*

Clients who had used some of the information

Four mothers already knew and had tried some of the advice/information and therefore selected parts of the advice/information that was new.

(Client 38)

'We already knew some of it.'

(Client 74)

'Well a lot of things that she mentioned I had already tried and failed, like trying to sit and read a book with him and in the end it failed.'

The remaining client whilst agreeing with the advice/information observed that it was difficult to follow. The discussion with the HV had focused on the problems in the relationship between a new mother and her partner due to tiredness and a succession of life events.

(Client 86)

'We have always had a relationship where we could always talk to each other about anything ... since Alwyn has been born its been strained, your both tired and Michael [husband] *is as tired as I am.'*

Clients who might use some of the advice/information

Two mothers had not reached a decision about what action to take. One in respect to whether to have her child immunised:

(Client 51)

'I'll make a decision later.'

The second mother who had discussed relaxation with the HV did not appear confident she would be able to follow the suggestions.

(Client 116)

'I can't really say yes or no or not can I, I don't know ... I know I should say yes.'

The nature of some (n = 45) of the issues discussed were not appropriate to the question regarding the *use* of advice/information. The outcomes of these discussions were of three types: reassurance, referrals or discussion of feelings.

Reassurance

Twenty five clients held a discussion with the HV regarding the mother's concern about a health item, child development or management of an issue. In these cases the advice/information given by the HV resulted in no further or no different action being needed by the mother.

(Client 26)

'I wanted to check, there are so many changes in what they say you should do.'

Eight mothers in this group received an explanation from the HV which centred on increasing the mother's understanding of the situation rather than providing information to enable her to *do* something.

(Client 96)

> *'She* [HV] *explained certain things that could be causing the problem which put my mind at rest I was a bit worried and she managed to ease my mind because I was thinking the worse.'*

Referrals

Twelve clients discussed a referral for their child (usually for speech or audiology) or the HV liaising with another agency for the mother. In most of these situations it was what the *health visitor* was going to do following the visit rather than any action from the mother.

(Client 115)

> *'She's* [HV] *having a word with a doctor at the children's centre who specialises in children similar to Clive, like behavioural things. She won't make an appointment to see her but she* [HV] *will ask her and give her his case history and what we've tried to do, and what we can do next with regards to Clive.'*

Discussion of feelings

The primary focus for the visit for eight mothers was talking about their feelings and the outcome of these discussions lay in the ventilation of emotion.

(Client 6)

> *'Because you get to say things and she's* [HV] *got no family involvement so she really can't pass judgement.'*

Summary

Very few mothers stated that they would not use at least some of the advice/information received from the HV. When this response occurred it was usually (n = 5) because the

advice/information was already known and not required by the mother. In one further case a mother changed her mind following the discussion with the HV.

The nature of some discussions between the HV and the client did not result in a demonstrable outcome of the mother doing something or not doing something. In these cases the mother was reassured on some aspect of the child's management, care or progress, discussed a referral for a medical or social issue or talked about her feelings with the HV.

Section 9.5 Clients with no memory of a discussion with the health visitor

The transcripts and audiotape data for the eight clients who did not remember talking about any issues with the HV were examined.

Three of the visits were primary visits but all the mothers had at least one other child. One mother felt that there was simply no point in the service:

(Client 133)

> *'I don't think you have a need for them ... I mean if you have got a problem and your midwife is coming you ask her, other than that you see your doctor.'*

Another mother expressed no need for a home visit because of her experience of having four children.

(Client 60)

> *'With number four I would not really* [any point in having a home visit]. *Clinic wise I suppose to be able to ask advice and go to the clinic but first time visits at home doesn't really bother me - we've been there.'*

By contrast, the third mother appeared to still see a value in her HV visiting after the first child.

(Client 45)

'I think so because it does help just to be reminded I think you forget or get out of practice, it's just nice to talk.'

Another mother whom the HV was visiting because her youngest child was going to enter school stated that whilst the HV was useful with the first child she would prefer to use other sources of advice.

(Client 83)

'I think with you have got your first child you need somebody there, like me I didn't have a mum so I could ring up if I was worried, is okay to give her this, is it okay to give her that. Yeah there all right in that way but with your second one ... I would prefer to go to family or my friends. I would never think of picking up the phone and saying 'right I've got this problem. I would rather ring up my friends "Jackie I've got this problem", I would do that.'

A further three mothers had had their child weighed by the HV. These clients all commented they had no concerns about their child.

(Client 123)

'I asked her to visit in case I had a question but I didn't.'

The final client had two children on the child protection register but appeared to find the HV's visits acceptable.

(Client 113)

'No we don't mind her coming because she is nice. She's not really on the social services side because she is health isn't she.'

Summary

It is not possible to know precisely why some mothers did not recall discussing any issues with the HV. The lack of negative comments about the HV might suggest that lack of recall was not the result of a unsatisfactory HV performance.

Chapter 10 examines clients' descriptions of support provided by the HV during the home visit.

CHAPTER 10

THE MEANING OF SUPPORT TO CLIENTS

Section 10.1 Introduction

Chapters 8 and 9 presented client descriptions of advice/information received from the HV during home visits. Chapter 10 presents qualitative data from the same interviews resulting from open questions used to explore clients' responses when they stated that they had received *support* from the HV during the home visit.

Overview of clients' responses

All respondents were asked whether they felt the HV had given them support on the previous visit. Sixty eight mothers stated that support was not an element of the visit and were excluded from further analysis. In addition, one client was excluded because of language difficulties.

As the study seeks to clarify the contribution of the *health visitor* to the well-being of clients, data analysis regarding support was restricted to the 37 clients who identified the HV as the *sole* provider of the support they identified (Group A).

Analysis of the 37 transcripts and interview schedules yielded six categories referred to by clients when describing the meaning of support:

- 'Feeling bad':

The background to women needing support

- 'Other people':

Alternative sources of support available to the women

- 'She knows what she is talking about':

The role of advice or information in support

- 'Being there':

The importance of health visitors' empathy and caring.

- 'Lifting a weight':

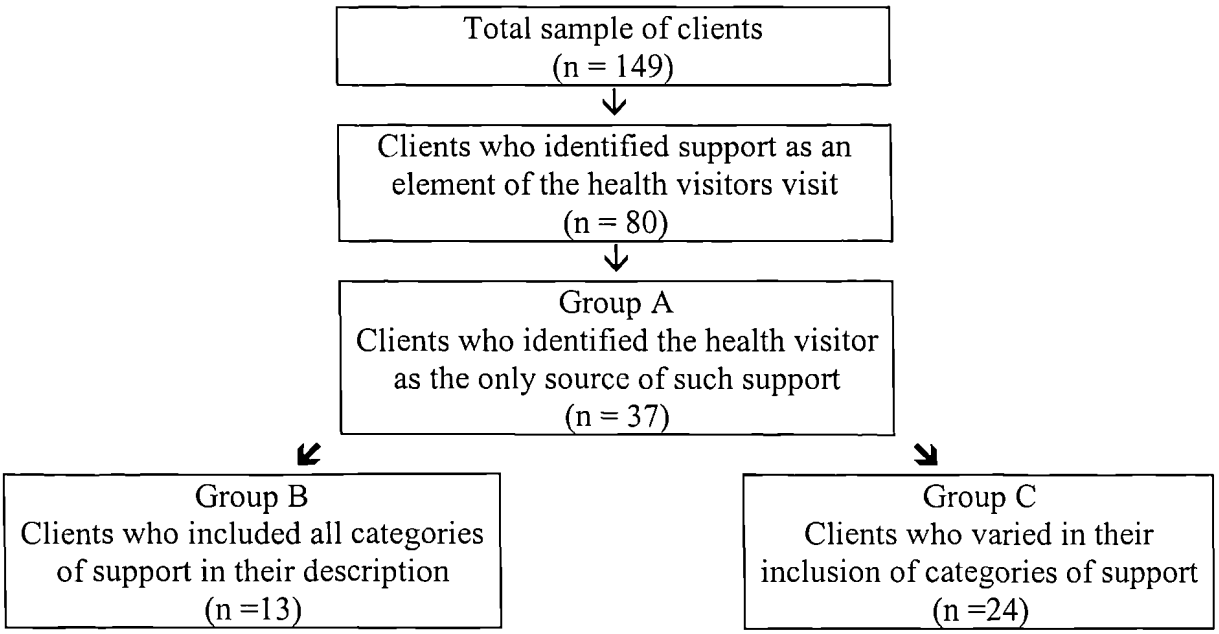
Linking outcomes with the visit from the health visitor

- 'Safety net':

Having someone to turn to should the need arise

A difference became apparent, within Group A, regarding the comprehensiveness of description and the effect of support reported. It appeared that Group A consisted of two subgroups (Groups B and C). The larger, (Group C) comprised 24 women who did not include all categories when they talked about support. In a smaller group of 13 cases (Group B), all clients included the same five categories in their description of support. However, Group B was also distinguished by the fact that no clients identified the 'safety net' category. Figure 10.1.1 illustrates the pathway for arriving at the groups for analysis of support.

Figure 10.1.1: Arriving at the groups for analysis of support



The difference between clients in reporting of categories is made more explicit in Figures 10.1.2 - 10.1.3 which show the reporting of categories by client in Group B and C.

Figure 10.1.2: Reporting of categories of support by Group B clients

Group B clients (n = 13) interview number	'Safety net'	'Feeling bad'	'She knows what she's talking about'	'Others'	'Being there'	'Lifting a weight'
12						
15						
17						
20						
39						
53						
55						
107						
112						
122						
126						
128						
131						

Denotes client included category in description of support

Figure 10.1.3: Reporting of categories of support by Group C clients

Group C Clients (*n* =24) interview number	'Safety net'	'Feeling bad'	'She knows what she's talking about'	'Others'	'Being there'	'Lifting a weight'
6						
11						
18						
23						
31						
33						
34						
35						
40						
41						
50						
51						
58						
65						
71						
72						
73						
93						
97						
102						
115						
117						
137						
145						

Denotes client included category in description of support

The data analysis begins with reporting mothers in Group B. Following this, an account of Group C illustrates the differences in responses given between the Groups. This account includes a description of the 'safety net' category.

Section 10.2 Descriptions of categories reported by clients in Group B

Category - 'Feeling bad': The background to women needing support (Group B)

This category describes certain features that appeared to be shared by the women. There were common themes to these stories: a concern of at least several weeks duration, predominance of psychological problems, mother-centred rather than child-centred discussions and, in most cases, frequent contact between HV and client.

Problem duration

The length of time mothers had been experiencing an issue of concern ranged from three weeks to over a year. Six clients reported being depressed for between five weeks and several months. Another four described a history of distress connected to the present issue which had lasted between five months and two years. Two further women with mental health problems had experienced difficulties over a number of years. The final mother's child had had a behavioural problem for a year before seeking help.

Frequency of visiting

The frequency with which clients reported being visited is shown in Table 10.2.1.

Table 10.2.1: Frequency of visits by the health visitor

Frequency	Number
weekly	4
fortnightly	5
monthly	1
up to three monthly (according to mother's need)	3
Total	**13**

One woman had only had two visits from the HV. The remaining clients had known and been visited by their HVs for at least several months.

The visiting patterns were not fixed but varied according to need. For example one woman in the weekly category was starting to have fortnightly visits and another mother in the

three monthly/as necessary category had been receiving weekly visits for two months. In addition to these arranged visits there was frequent reference to telephone contact with the HV as necessary.

The focus of the visit

Issues described by mothers as discussed with the HV are summarised in Table 10.2.2.

Table 10.2.2: Issues described by mothers

Problem	Number
post natal - depression/anxiety	6
specific problem	4
mental health problem	2
bereavement (stillbirth)	1
Total	**13**

The majority (n = 9) of problems encountered by women were issues concerning psychological health, with a focus on the post natal period (n = 7). Not surprisingly, these women reported discussions that centred on their emotions and which included explorations of tactics to manage their current psychological difficulties. This did not preclude advice and discussion regarding children, but this was usually not reported as the most important issue discussed.

Four mothers were being visited by the HV because of specific problems concerning children: behavioural problems (n = 2); illness (n = 1); development (n = 1). However, these problems could not be divorced from the mother's psychological state. Notwithstanding appreciation of the advice given all mothers described the major benefit of the visit as the difference it made to how *they felt*.

Two clients described what might be interpreted as empowerment. That is they described the HV as giving them a sense of confidence they could manage the situation. One mother who described herself as 'at the end of my tether' stated:

(Client 39)

'It made a lot of difference ... without her I wouldn't have gone through with it.'

The second mother described a difference in how she felt as a result of the HV's intervention:

(Client 128)

'The most helpful bit I think was the encouragement, she makes a point of saying you did it before you can do it again. And it was all new to me last time so she sort of boosts up my confidence.'

This mother reflected later on:

'... she made me feel like a mother again ....'

The remaining two mothers reported the sense of benefit that accrued from the HV in addition to advice/information.

(Client 107)

'Well I think the most important thing I get from Jenny [HV] you know when she comes, you were asking about whether she talked any information, she has got a really caring attitude ... well that's what it is a caring attitude.'

and:

(Client 53)

'because it is not just the information is it its not just yes or no do that, do that, its what it does to you as well, I think. Not just the fact that yes you are doing the right, but then you feel better, then you can carry on doing it. It not just yes, don't put sugar in his tea but you are doing right ... I can't explain it really but I know what I mean, she reassures really just by turning up.'

Both these clients returned spontaneously throughout the interview to the importance of the care and reassurance they received from the HV.

Summary

Problems of at least three weeks duration were reported by all clients. In addition, some mothers described a background of distress of at least several months. In most cases contact with the HV had been frequent and regular.

Discussions between HVs and clients focused on the mother in these cases. Issues concerned with the child were also raised. However, clients usually identified the most important input by the HV as the effect on their psychological well-being.

Category - 'She knows what she is talking about': The role of advice or information in support (Group B)

Clients described three ways in which HV's advice/information provided support: identification of problems; management of problems and reassurance.

Identification of problems

Three women, who had felt bad, but did not know what was happening to them sought medical help for post natal depression following suggestions by their HV that this was the cause of their distress.

One client explained that although she was worried she might become depressed and was therefore alerted to the possibility, she did not realise what was happening to her:

(Client 126)

> *'I had read about it through my books and leaflets but I thought it would come straight after because I was depressed in hospital ... felt real down over Christmas, and he was waking up all the time and I thought that was when it happened. Five weeks down the line I didn't expect it. I just felt down in the dumps and tired and I thought it was due to getting up and looking after him. Once I explained how I was feeling she said it could be post natal depression*

and explained what the doctor would do and with anti-depressants it would take a while before it got better.'

One further client with mental health problems contacted her psychiatric nurse after discussion with the HV and another client with mental health problems was discussing the possability of seeking psychiatric help for her depression.

Advice

One client was grieving for her stillborn child and experiencing fear and anxiety about her current pregnancy. The HV was the only person with whom she was able to discuss and try to understand these strong emotional experiences.

(Client 122)

'... She seems as though she knows and she can read my mind and knows what's happening. She just explains to me like we do it in hurdles. Like she will say "this is another hurdle you have to get over" and maybe next time I'll tell her that I've been having nightmares again and she'll say "right then lets go back to the last time and get over the hurdle" she's just understanding it feels as if she knows exactly what's happened.'

The second mother had had to adjust to her child having a life threatening illness.

(Client 107)

'I just started to acknowledge what was going on like because I didn't basically know anything about it, I was getting down because I didn't know. So she was trying to get all the information that she could and what it was about. So that it made me better having a lot more control.'

The advice/information about these different problems made the situation more intelligible to mothers, which they described as helping them *cope* with the problem.

Another mother experiencing post natal depression and panic attacks described how her HV monitored and co-ordinated the professionals involved in treatment, accessed

information for her, and initiated referral to an additional agency, as well as being a source of advice and encouragement.

(Client 12)

> *'Annie* [HV] *always seems to give me more time than the actual GP does plus if she'd not said about the CPN I would never have thought to ask for one myself, I mean I'd been taking tablets for about three weeks before the health visitor referred me to the CPN so obviously the Doctor wasn't going down that road, Annie has certainly helped me more than the GP.'*

Two further clients, whose children had behavioural problems received advice from the HV which they reported as crucial in managing the problem. Both mothers referred to the enabling manner of the HV in convincing the mother she could deal with the problem effectively, but the quality of advice was an important aspect of the success of managing the change according to these clients.

One client whose child had been experiencing behavioural problems described the quality of explanation and guidance provided by the HV as crucial in enabling her to change her child's behaviour.

(Client 39)

> *'She tells you things that I wouldn't have done like I wouldn't have dreamed of putting him in the bedroom on his own, but she said I don't know its what she says I seem to believe you know, I believe her on everything.'*

<u>Reassurance</u>

Three mothers were particularly anxious about their child's health owing to previous problems. According to them, reassurance from HV's advice/information accounted for part of the support they derived from the visits.

(Client 53)

> *'... I get so, I mean I'm insecure as a mother when they are ill. Its important that ... it is just important that she makes you feel that you are doing the right thing, you are not doing the wrong thing.'*

Accessibility

Five mothers described the HV as an accessible source of help who was always available for the mother to turn to.

(Client 131)

> *'... it is not the case of I see her one day in the week and I've got to see her the next ... it is the case of she is there at all times. She is always saying to me that without fail you know where I am ring me if you need me.'*

One mother contrasted this with the difficulty of getting an appointment with her GP.

(Client 20)

> *'... you have got to book like two weeks in advance and when you are worried and you want somebody who you can talk to sort of there and then not to have to make an appointment and wait two, three weeks ... and then sometimes you have got to see a doctor who doesn't know you.'*

Professional

A further five mothers highlighted the role of the HV as a *professional* source of knowledge. This was perceived as more trustworthy than other sources of knowledge available to them.

(Client 20)

> *'I always think Maggie* [HV], *I mean I take notice of what he* [husband] *says but then I think hang on Maggie is a professional, what she says she knows what she is talking about, even though he'd say the same, I'd still take it from her.'*

Summary

As in the first category 'feeling bad', all women in Group B had problems which included a component of depression and/or anxiety. Through the accounts of these difficulties it is evident that HVs contributed practical advice/information by helping identify problems, devising coping strategies, accessing other professionals and specialist information as well as providing a source of expertise themselves.

Category - 'Other people': A description of the alternative sources of support available to the women (Group B)

Amongst other things, the role of the HV will be shaped by the client's perceived need for that role. All women in Group B viewed the HV's contribution as unique. They did not feel the input they received from their HV in terms of advice, information, confidence-boosting or emotional comfort was available from other sources. This appeared to be for two main reasons: minimal personal networks or difficulties in their relationships with partners, family or friends.

Partners

Four women were single. The remaining nine women described partners offering some positive but limited contribution (n = 7) or being unable to help (n = 2). Contributions by partners were limited because of sharing the same anxiety as the mothers or because the women felt they had to be careful of over burdening their partners (n = 3).

(Client 131)

> *'He is just as concerned as me, do you see what I mean ..... It is all right saying that we could discuss it, we can discuss it until we are blue in the face but it still won't put either of our minds at rest.'*

(Client 12)

> *'If I talked to Steve all the time it would make him depressed too.'*

Four further clients stated their partners had limited ability to understand and sympathise with what they were feeling.

(Client 53)

'No not in the same way, really [able to support]. *I mean my husband was so opposite, he's cool and laid back and I'm the panicker and worry and I complain if the stuff isn't right in a restaurant and he would just sit there and say nothing. We are very opposite. That sounds awful really because he does, he supports me anything that I want to do he is right behind me. But on the other hand he knows that nothing that he would say would make me feel any better really.'*

For the remaining two women, tensions with their partners meant that it was difficult to talk about the situation that was causing concern. The tensions were reported as pre existing within the relationship or actually results of the problem the woman was experiencing.

(Client 122)

'... part of the time, most of the time it is to do with him so it is a bit difficult .... It probably sounds like I am complaining about him ....'

Family

Talking about the family to the researcher usually meant talking about the mother or mother-in-law.

Four women described how maternal grandmothers or mothers-in-law could inadvertently increase the strain of their situation by lack of empathy.

(Client 126)

'My mum knows my partner and she knows that we don't really get on, that we haven't been getting on because of the way I have been feeling, and that upsets her because it upsets me, so she starts bringing him into it.'

One further client who valued the relief she got from her child sleeping with his grandparents on occasion also found their handling of him exacerbated his sleep problem.

Two of the women described friendly regular contact with their own mothers but also commented on their mothers' limited ability to offer help in the situation.

(Client 131)

> *'she* [maternal grandmother] *has never been through what I've been through, so she couldn't begin to understand how we feel, do you understand what I mean? It is really awkward to explain to you but unless you have actually gone through it you can't begin to understand how a person feels and even me mum says that.'*

The remaining six clients had either no family members or no viable relationship with them.

Friends

The limitations that could occur with partners and family could also occur with friends. Seven clients reported that friends did not necessarily have the information, skills or patience to help. A difficult situation such as bereavement or termination could result in additional isolation for the woman because people did not know what to say or how to act. One person recognised that friends had lives of their own and there was a limit to the amount with which you could expect them to cope.

(Client 17)

> *'And like friends, I mean you don't always want to be visiting a friend and all you seem to be doing is moaning about my problems .... Obviously after a while they don't really want to know. Well it must get them down.'*

In addition, three clients did not perceive friends as trustworthy in a general sense or specifically trustworthy regarding the client's thoughts and feelings.

(Client 15)

> *'They aren't interested, they haven't got time, and they just laugh. Some people just laugh because they don't understand what it is all about.'*

One person reported that her social network consisted of a neighbour; and two clients did not describe any friendship network.

Other professionals

The general practitioner was the professional with whom the client was most likely to have contact apart from the HV. Two women were positive about their general practitioner: *'He's the bees knees. I would be lost without him'* (client 131). The remaining clients held more mixed views.

Four clients, while offering no complaints about their GP, compared this service unfavourably with that of the HV. This comparison was drawn in terms of accessibility, time available for discussion, and ease of talking.

(Client 20)

> *'... they will say make an appointment to see your doctor so like I say that would be like next week or the week after when you want somebody to talk to and sort out there and then.'*

(Client 12)

> *'Well my doctor doesn't always have enough time of course to give me what I need or tell me what I like to hear, I mean Dr Johnson was good when he came here because it was a home visit I got a bit more time but if you go to the surgery you only get five minutes ....'*

(Client 122)

> *'He's* [GP] *quite good but I feel I can only talk to Sally* [HV]. *Like she says to me if you can't get hold of me or something like that always ring your GP. But I don't feel I don't because I feel I can only to talk to her.'*

Three further clients did not perceive their doctor as an appropriate person to discuss problems with. One commented:

(Client 112)

'GPs are, they get paid by how many people they see so you are in and out in five minutes.'

Two women reported medical staff had been dismissive and unknowledgeable when approached concerning a problem with their child, and that they would therefore not seek further help from them in this regard.

(Client 128)

'I talked to the doctor about his sleeping and he sort of pushed it to one side and said he'll grow out of it, he's just going through a phase, it isn't very useful when you're in the middle of it.'

One further client described her visit to the GP as follows:

(Client 126)

'Generally, he sat there and I said my health visitor asked me to come and see you because I have been feeling really depressed and he said "oh right post natal depression is what you are suffering from" and he said "so many percent of women suffer from it and I'll put you on these tablets and come back and see me in a month". He did say that you have got to make time for you and your partner, just to pop down to the pub for a quick drink, and that was it.'

The client's phrases *'he sat there'* in the first line of the text *'and that was it'* in the final line of the text might suggest ambivalence on the part of the client in terms of satisfaction with her visit to the GP.

The final client did not make any comment about her GP.

Summary

The women in Group (B) were experiencing difficulties that were not shared by most parents. Therefore the parenting experience of family and friends might not be able to provide the type of support the women required.

In addition, the consequences of the situation could create extra tensions making it more difficult for family members to cope with the needs of the women. Clients were aware of people around them being a limited resource. It could be posited that the mental health problems suffered by most of the women might also contribute to their finding it difficult to relate to other people.

Therefore the presence of a social network was not according to these women sufficient to meet their needs for advice, information or discussing feelings.

Where clients were also seeing other professionals, HVs were described as offering a valued service not offered by the other workers.

Category - 'Being there': What feels important to the woman about the visit from the health visitor (Group B)

Clients described skills and qualities of their HVs that could be described as communication skills, empathising and communicating caring.

I can talk to her

All mothers made reference to the importance of being able to talk to the HV. This included both someone being *available* with whom to discuss problems and also the idea that there was something *special* about speaking to the *health visitor.* Seven clients commented on the ease with which they could discuss issues. The following were reasons offered by some mothers to explain this sense of ease: willingness of the HV to discuss anything, not feeling patronised by the HV, experiencing genuine interest from the HV.

(Client 12)

> *'I feel really at ease with Sally* [HV] *I can really talk to her. She'll always give me time and help if I ring up, if I'm anxious or anything she'll always speak to me on the phone so she is a person I can really talk to.'*

(Client 53)

> *'... but she doesn't preach but she does help and she does advise but she doesn't do it in a way that you think 'she's the health visitor, I'm the mother. '*

Four clients reported there was no one else available to whom they could talk, due to social isolation and/or the sensitive nature of the problem such as mental illness, post natal depression, bereavement or chronic illness.

(Client 55)

> *'Well I haven't really been able to talk to anybody about my problems, people are always talking to me about their problems and I can talk to her about my problems.'*

Where mothers did have others they could talk to, these conversations were compared unfavourably with talking to the HV. Relatives and friends did not possess the objectivity of the HV. Objectivity was viewed as the HV not being affected by the problem, allowing her to focus on the needs of the mother. In addition, the HV did not introduce a personal perspective, which some mothers observed was a risk with friends and family. Consequently, the mother was able to express what she felt without censure or without upsetting other people.

(Client 17)

> *'They are not close to you so you can tend to talk and say things to them that you can't say to your parents and your family.'*

<u>Like a friend</u>

Although the HV might be valued because she was not involved either in the problem or in the family dynamics, the idea of a relationship which included a sense of personal involvement was important to some mothers. Five mothers raised the notion of friendship. This was linked to enabling clients to feel they could talk with the HVs.

(Client 107)

> *'She is more like a friend not like a health visitor, you know what I mean, she comes in and she talks to you at great length, she will sit and talk. She will sit and talk, you know just about anything, about having the children, about how I am feeling, you know what I mean. Its not like you are talking to a health visitor.'*

Four mothers clarified their description of friendship by contrasting it with a professional visit by the HV or other workers. The implication was that the HV's visits had a quality a purely professional visit lacked.

(Client 131)

> *'... in some respects I treat her more now as I sort of call her Sue and she is not a health visitor, I think oh Sue is coming this week its isn't oh the health visitor is coming, it is sort of oh Sue is coming ... and its you not sort of a, not sort of a professional visit its just like somebody coming to see you a friend ....'*

It was noted earlier (p 301) that clients' described the limitations of friends due to lack of knowledge, lack of understanding and lack of trustworthiness. These negative descriptions were *not* applied to the friend relationship that mothers described with their HV.

In addition one client while not describing her relationship with the HV as one of friendship explained that she felt able to talk with her partly due to her friendliness.

(Client 55)

> *'Partly because she is a woman and partly because she is sort of friendly.'*

<u>She understands</u>

Six respondents highlighted the importance of HVs demonstrating 'understanding', which might describe an empathic *or* intellectual quality. Clients uniformly referred to understanding in terms of sensitivity shown by the HV to the mother about the problem. For one mother, understanding meant that her problems, which she felt others were embarrassed to recognise, were acknowledged by the HV.

(Client 20)

> *'I think most people that you would tend to* [talk to] *get oh its all right what are you worrying about. But when you talk to somebody else they say I can understand you have definitely been through a lot and sort of you think well yeah you know I have.'*

The remaining five mothers associated understanding with insight into their feelings.

(Client 128)

> *'She appears to understand an awful lot more, she seems to actually come down to what I am feeling.'*

She listens

Six clients identified having somebody prepared to listen to them as an element of support offered by the HV. Another mother whilst not mentioning listening appeared to imply this by her description.

(Client 17)

> *'I can say to her I've had a really horrible day today Jenny [HV] and she'll say "oh really what was it?" and I'll say "it was so and so" you know and she just sort of like takes it.'*

Six mothers commented either that there was no one else in their social network who would be interested in listening to them or that other people did not listen in the same way as the HV. For example one woman with close contact with her mother contrasted the listening of the HV, who focused on the client's needs, with the listening provided by her mother who also provided her opinion.

(Client 126)

> *'My mum would have listened but she probably would have also started like saying do this and don't do that, giving her view across whereas my health visitor just listened ... the health visitor just talks to me.'*

Caring

Many (n = 9) client comments suggested the HV was seen as trustworthy, caring and interested in the mother. Three clients reported *'I know she is there for me'* (e.g. client 131) and a fourth commented:

(Client 20)

'... to have somebody sort of on your side ... to say you are not daft, you are not thick ... you know someone on the outside looking in.'

The concept of caring was raised explicitly by three clients. This appeared to encompass a feeling that the HV had a genuine interest in the woman, which two clients contrasted with previous experience of professionals including HVs.

(Client 112)

'I think most health visitors I've seen come across either as false or they just treat it because it is a job and they get paid so much a year. Whereas on the odd occasion you get somebody like Ellie [HV] *or in another profession who actually do care.'*

Two further clients commented they felt they could trust the HV.

(Client 53)

'You can put your trust in her.'

Summary

Clients reported HVs using communications skills and displaying empathic qualities which were apparently valued by the clients. The importance of talking to the HV appeared to be heightened by the fact that many women reported that they had *no one* they could talk to who would be interested in them and who would be non-judgmental about the issue under discussion.

Category - 'Lifting a weight': Linking outcomes with the visit from the health visitor (Group B)

Women in Group B stated there were positive changes in their life attributable to the visit or visits of the HV. These changes might be observable, as in the case of seeking psychiatric help or an issue with child management. However, the majority of stated outcomes concerned *perceptions* held by the women about the ways in which the HV had

helped them. Clients provided reports of HVs preventing psychological deterioration and increasing the mother's coping abilities.

Making a difference

Five mothers linked the last visit from the HV with a specific beneficial outcome. One mother had been receiving visits from the HV because of post natal depression. This client identified the HV as being instrumental in her seeking help since the last visit from the HV.

(Client 15)

> *'It was about myself* [the discussion], *that if I don't get help I'd probably end up hurting myself or hurting Tommy. So she said to me about how I needed help.'*

According to this mother, without being able to talk to the HV in the first instance and receiving the subsequent help, her condition might have deteriorated and led to her being unable to look after her child.

> *'I would probably have cracked up ... I wouldn't have been able to look after Tommy.'*

Another woman with post natal depression also viewed the HV as pivotal to her being able to deal more effectively with her emotions.

(Client 126)

> *'If I hadn't been able to talk to her and she hadn't offered to come round to listen then I would have bottled it up and got worse because I'd try and talk to my partner about it but he doesn't understand.'*

Two mothers reported that a sense of confidence they could manage their problem, and which resulted from the visit was instrumental in their feeling better. In one case the client had a history of drug misuse. According to this mother she had felt less depressed after talking with the HV and this was a factor in her not using drugs.

(Client 112)

'When she came round I felt a bit low, and after she left I felt a lot better and just talking to her and I was a bit down and having to do everything, and having someone else say that they believed in me and I think I can do it.'

The second mother was coping with a child with a long term health problem which led to child management problems. She emphasised the importance of the increase in self confidence which followed discussion with the HV. The mother reported that HV's visit was critical in stabilising her situation.

(Client 128)

'I think that if she hadn't been at that point, by this week I would have been really low and depressed.'

The fifth mother described the HV's intervention of teaching her how to manage her child's problem behaviour. The client had used the technique successfully but attributed this success to the interest and skill shown by the HV in explaining and demonstrating child management principles. As important, from the mother's perspective, was the ability of the HV to convince her that she was able to change her child's behaviour. The mother stated that without the aid of the HV the child's behaviour would have remained the same.

(Client 39)

'He'd still be the way he was. She gave me the courage you know to put him in there and do it and she said to me you know if you want to stop it you've got to do it.'

Feeling better

For a further six clients feeling better after the HV's visit was equated with a reduction in feelings of anxiety.

(Client 17)

'I do feel a hundred times better after she has been. I mean the visits are getting shorter and shorter, the first time she was here for a couple of hours,

but they are getting shorter and shorter. I think as I am getting better she can sense it and so she is not staying as long, but even knowing that she is coming and that I've got some one else to talk to, its a lot better.'

(Client 12)

'After she'd had a little discussion with me I just felt so much more better, as though my battery had been recharged, just by the things she'd been saying.'

she explained:

'It means to me almost back to normal and relaxed again.'

(Client 122)

'It gets rid of all the tension, I feel when Sue's [HV] *been I feel as though, I have this big lump here and when's she's gone I feel she's taken all my troubles with her.'*

Coping

Two mothers reported this reduction in anxiety enabled them to cope better with their situation.

(Client 131)

'I don't feel as near as anxious after she has gone, no matter. I think towards the end of the week I can ... maybe a few things I want to ask her so I start to get myself in a bit of a worry that I am going to remember to ask her this and am I going to remember to ask her that, by the time she has gone I am fine, do you know what I mean, I feel at ease to get on with it.'

The two remaining clients placed descriptions of feeling better within an ongoing context of being supported by the HV. One mother reported that her growing ability to believe her child was thriving was due to constant reassurance from the HV.

(Client 20)

> '*I think it is because of all the help I've had. Because of all the help I've had and Sue* [HV] *saying he's lovely, look he is, all these checks and she's been putting him on the graph to see him grow, and she is saying yeah everything is fine, he is average, and he's put just the right weight on and he is doing everything he should be doing, everything he should be doing.*'

The second mother was caring for a child with a life threatening illness and had had numerous problems over the previous months, with which the HV had helped her deal. According to this mother, without these frequent visits '*I think I would have packed up*'.

(Client 107)

> '*If it wasn't for Sue,* [HV] *having her to talk to, I think I would have got really depressed.*'

Summary

All clients identified the visit from the HV with feeling better. Feeling better included reduced anxiety, being reassured, feeling more able to cope with the situation. The majority of clients had been visited by the HV on a regular basis and all mothers stated that being visited by the HV had brought benefits in terms of their well-being or being aided with a problem. In five cases the previous visit of the HV was linked with a specific positive outcome for the client.

SECTION SUMMARY

Clients in Group B reported current or former problems which they regarded as difficult. Mothers reported that the support received from the HV was instrumental in helping to manage these problems as well as making them *feel* better. The reported contribution of categories and themes within categories varied between clients. However, clients in Group B included all categories in their description of support. This suggested clients in Group B held a multi-faceted concept of support.

Section 10.3 Descriptions of categories reported by Group C clients and comparison with Group B

Section 10.2 reported that Group B was distinguished from Group C by two factors. Clients all referred to the same categories in describing the meaning of support from the HV, and no client mentioned the 'safety net' category. Section 10.3 continues examination of the qualitative data by reporting the responses from Group C clients.

In addition to the differences in categories raised by the two Groups there were differences in the proportion of respondents who described themes within each category. Three categories ('she knows what she is talking about' 'being there' and 'feeling better') had differences in themes identified by Groups B and C. An overview of these differences is shown in Table 10.3.1.

Table 10.3.3: Categories and themes raised by Groups B and C

Group B (n = 13)			**Group C (n = 24)**	
Category: 'Feeling bad'			Category: 'Feeling bad'	
Theme	Number (%)		Theme	Number (%)
Problem duration	13 (100%)		Problem duration	3 (12.5%)
Frequency of visits	13 (100%)		Frequency of visits	3 (12.5%)
Focus of visit	13 (100%)		Focus of visit	3 (12.5%)
Category total	39		Category total	9

Category: 'She knows what she is talking about'			Category: ' She knows what she is talking about'	
Theme	Number (%)		Theme	Number (%)
Identification of problems	4 (30.6%)		Identification of problems	0 (0%)
Advice	9 (69.2%)		Advice	8 (33.3%)
Accessibility	5 (38.4%)		Accessibility	6 (25%)
Professional	5 (38.4%)		Professional	5 (20.8%)
Reassurance	3 (23.0%)		Reassurance	3 (12.5%)
Category total	26		Category total	22

Category: 'Others'			Category: 'Others'	
Theme	Number (%)		Theme	Number (%)
Other professionals	12 (92.3%)		Other professionals	5 (20.8%)
Friends	10 (76.9%)		Friends	7 (29.1%)
Partners	9 (69.2%)		Partners	5 (20.8%)
Family	7 (53.8%)		Family	17 (40.8%)
Category total	38		Category total	34

Category: 'Being there'	
Theme	Number (%)
I can talk to her	13 (100%)
Caring	9 (69.2%)
Like a friend	6 (46.0%)
She understands	6 (46.1%)
She listens	6 (46.1%)
Category total	40

Category: 'Being there'	
Theme	Number (%)
I can talk to her	6 (25.0%)
Caring	0 (0%)
She's friendly	6 (25.0%)
She understands	3 (12.5%)
She listens	5 (20.8%)
Category total	20

Category: 'Feeling better'	
Theme	Number (%)
Feeling better	6 (46.1%)
Making a difference	5 (38.4%)
Coping	2 (15.3%)
Category total	13

Category: 'Feeling better'	
Theme	Number (%)
Feeling better	8 (33.3%)
Making a difference	0 (0%)
Coping	0 (0%)
Category total	8

Category: 'Safety net'	
Theme	Number (%)
Backup	0 (0%)
Category total	0

Category: 'Safety net'	
Theme	Number (%)
Backup	10 (41.6%)
Category total	10

(%) = number of clients who raised theme as a percentage of the total number of clients in the Group.
Category total = total number of times a theme was raised.
Clients sometimes raised more than one theme.

Responses from Group C clients

Section 10.3 provides details of the categories reported by Group C together with comment on the similarities and differences between Groups C and B. The section begins with a description of the 'Safety net' category that was *only* reported by clients in Group C.

Category - 'Safety net': Having someone to turn to should the need arise (Group C)

Backup

Ten mothers reported feeling supported knowing that the HV was available for advice and help if an unexpected problem arose. Five clients referred specifically to offers of help given by the HV during visits.

(Client 40)

> *'... she said if ever I need her this is the contact number, it doesn't matter, and if you can't get hold of me, you can get me there. So she seems really good.'*

A further five mothers referred to knowing the HV was there if they needed her.

(Client 65)

'A lot of it is instinct but it's still nice for someone to back you up.'

The majority of mothers (n = 8) appeared to view this potential backup as centred on meeting the needs of children. Given that most (n = 8) women had more than one child it appeared that previous experience of parenthood did not exclude the potential usefulness of the HV. One possible explanation was provided by a woman with six children who commented that all children were different and therefore previous experience with children did not necessarily equip you for *all* eventualities.

(Client 11)

'Well I suppose you always know there's somebody there sort of thing if needed, I mean you go on your own experience but if there's something what comes up I mean all children are different aren't they and if something comes up you know there is someone there.'

However, two clients modified their remarks about back up from the HV by adding that they did not think that it was a service that *they* actually required. Both mothers observed there ought to be a service for those mothers who might need it. One remarked that back up of this kind was predominantly useful for first time mothers.

(Client 65)

'... when I was in with this one [fourth child] *that I just felt that first time mothers there was no one there for them and I do remember having my first, and you've got so many questions, its just something you have never done.'*

Two women experiencing personal problems perceived the HV's offers of help as including *their* needs as well as their children's.

(Client 137)

> *'She* [HV] *said if she* [CPN] *isn't available you know you can always come and talk with me. And she said even if I have got any medical problems with myself or with the children to get in contact with her because she knows nursing and all like that. So that is supportive.'*

Summary

Mothers who did not have problems with their children apparently still valued access to the HV *in case* problems arose. Having more than one child did not affect this perception for most clients. Most comments were focused on the use of the HV in helping the mother with problems with child health rather than issues about the mother.

Most mothers in Group B *were experiencing or had experienced* problems which had been helped by HV. This might explain the lack of reference by Group B clients to the *potential* use of the HV described in 'safety net category'.

Category - 'Feeling bad' (Group C)

Three women in Group C (n = 24) recounted personal stories of established problems that had continued over a number of months.

Duration of problem

The nature of the problems in Group C appeared serious and continuing over time in a manner similar to those reported by Group B mothers. One mother was grieving for her brother who was in hospital with extensive brain damage following an accident six months previously. In addition, her partner had been receiving psychiatric treatment for some years. This client had just realised she was four months pregnant.

The second respondent had a child with an eighteen month history of severe behavioural problems, and was caring for two other children, including an eighteen month old child who was severely physically handicapped.

The third client recounted a two year history of depression for which she was receiving treatment.

Frequency of visiting

Two clients in Group C shared the characteristic of frequent visiting described by Group B mothers. However, this was not true for one Group C client whose visit from the HV related to a specific issue and was not part of a sequence of visits.

One mother did not report a history of frequent visits. The visit by the HV had been in response to mental health crisis experienced by her husband and afforded an opportunity for her to disclose *her* feelings.

The second mother had been allocated to her current HV only four months previously. The HV was visiting on a two monthly basis.

The third client reported receiving treatment for depression for over two years. According to the mother the HV had visited regularly during this time but had now reduced visits to bi monthly as the mother's mental state improved.

The focus of the visits

In two cases in Group C the main focus of the visit was an issue to do with the child. This contrasted with Group B when *all* mothers chose the effect on their emotional state as the most important aspect of the HV's visit.

For one mother in Group C the main focus of the discussion was her child and dealing with his problems. Unlike Group B mothers, she did not refer to feelings of depression or anxiety or to intervention by the HV as instrumental in helping her manage her situation. However the mother appeared to view the HV as a good source of advice and encouragement

(Client 115)

> *'Support means the first part is that she listens, she listens to everything I have to say, she understands, she gives me advice you know she doesn't try to fob me off and she'll try to help in anyway that she can and that for me is you know very good. I don't come away thinking oh what a waste of time, I come away thinking I'm really glad she came, I feel a lot better now.'*

A second mother regarded discussion about her depression as of secondary importance to talking about her child's speech.

(Client 50)

> *'... It was more a professional information that she could give me in that instance but as for me when she was listening to them she gave me that extra support, but because it* [the visit] *mainly concerned Jack it was more important for me to hear what could be done about his speech and for him to get help.'*

By contrast the third mother discussed issues to do with her child as well as herself but regarded the main benefit of her discussion with the HV as someone listening to *her* problems.

(Client 35)

> *'She helped me in a lot of relief she helped me in the bairns progress, she helped me and listened as well. Being listened to is important because I am the one who has to listen so when I get listened to its different and its good, its a good feeling.'*

Summary

Problems existing over time or a history of a problem which still led to anxiety on the part of the mother were features of all mothers in Group B. By contrast such experiences were recounted by a small proportion (12.5%) of mothers in Group C. In addition, the three mothers who described problems in Group C did not describe the sense of loss of control or reliance on the HV that Group B detailed. One mother in Group C stated that her depression was very much 'better' than it had been during the last two years. It may be that diminishing involvement with the HV was a reflection of getting 'better'. There was no obvious reason why the two remaining clients appeared less distressed or reliant than clients in Group B.

Category - 'She knows what she is talking about' (Group C)

Eight women in Group C who included advice given by the HV in their definition of support did so in relation to advice they received on an ongoing basis. A further three

women described the advice they had received on the previous visit. In addition, three clients valued the advice received on the previous visit for the reassurance it provided.

Advice

Advice described by most mothers in Group C concerned potential or actual help for problems with their children. Mothers in Group B also gave examples of receiving advice for their children but usually also referred to advice for themselves or the way in which the advice about their children had helped *them* cope.

Eight clients in Group C stated that part of the support they received from the HV was the ongoing advice about their children.

(Client 18)

> *'... I mean she does give me a lot with these two and she does tell me a lot about her* [child] *and what I should do with her and that.'*

These mothers usually spoke of advice predominantly for their children. However, one respondent viewed advice as encompassing more than their child's health.

(Client 145)

> *'... in a way having a health visitor like Jenny is like having a doctor's surgery to a certain extent, available to you when he is not there, you know she can come and give you advice on other things apart from the child's health.'*

One mother observed that in her view support from the HV was restricted to advice on practical issues.

(Client 58)

> *'... I mean she has helped me no end with practical problems but emotionally not as much.'*

This client explained how in her opinion, the perceived role of the HV inhibited an open exchange between parent and HV.

'Its just the image, you know you think you have got to do everything right and like Jill [daughter] *had just burnt her hand the week before, she'd put it in the ashes bin, I thought oh no, I was so paranoid that she was going to think I can't cope and I was just working myself up more and more thinking she is going to think I am a lunatic and I can't do this and I can't do that and I was really panicking.'*

Unlike Group B, the HV's role in identification of problems for the clients was not apparent in Group C. This might be explained by most mothers reporting advice on issues that might be described as normal childhood ailments (e.g. colic and feeding problems). This contrasted with the more complex issues reportedly identified by HVs in Group B.

Allied to this was an absence of description in Group C about how HVs had helped the woman *understand* what was happening. Advice to mothers in Group C usually consisted of accessing solutions from the HV about discrete child management or health problems (e.g. how to deal with cradlecap).

Three women in Group C referred to advice given on a specific issue about their child during the visit as constituting support.

(Client 40)

'... she gave me some help, as I say I was bit concerned about the baby's spine and she was very good in that way, and she advised me what to do which I didn't know I could do, so that was quite good.'

Reassurance

Both Groups B and C had three mothers who commented on the feeling of reassurance they received from being able to use the HV to solve problems and check information about child care.

For three mothers in Group C the advice they received was not just valued for solving problems but for the sense of reassurance it provided.

(Client 31)

'When I talked to Annie I discuss any problems because he's got some lumps and she had a look at them and she didn't see there was anything the matter with him she just thought it was gristle and it put my mind at rest. You know I am always worrying about him with him being so tiny and I think its just that she is there you know and you feel as though she gives support. You get a lot of answers out of her.'

Accessibility

Mothers in Groups B and C highlighted availability of the HV and in both Groups this was contrasted with problems in getting an appointment to see the GP.

Six clients reported that a positive feature of the advisory role of the HV was that they could actually get in contact with her if they needed her.

(Client 97)

'You can just pick up the phone and nine times out of ten she is on the other end.'

One mother in Group C contrasted this with the difficulty of getting an appointment with her GP.

(Client 71)

'... because say for instance, because he did have really bad nappy rash and his bottom was virtually bleeding sort of thing, it would take me a week to get into surgery because you have to wait obviously to see a doctor, so then you'd be worrying for a week without any reason to. Whereas I can go straight down and see Angie or ring her up and I can know straight away what she thinks then I have got a second opinion ....'

Professional

Clients in both Groups provided the same interpretation of the notion of professional advice offered by the HV.

Five mothers in Group C commented on the professional nature of the advice given by the HV. The label of professional appeared to involve the notion of a trained individual whose information could be trusted and was assumed to be correct.

(Client 18)

'... she's trained and that so she must know ....'

Summary

Members of both Groups had mothers who identified the professional nature, accessibility and reassurance as useful features of advice from the HV. Advice for Group B predominantly affected the mother and included identification of problems. Advice for Group C clients was focused on child management and care issues. Although mothers in Group C talked of receiving advice on several occasions it was not generally concerned with a single issue but with a *variety* of concerns about child health or care. Clients in group B usually described a *core* problem that they had discussed on several occasions with the HV although they also referred to using the HV for advice on additional issues.

Category - 'Other people' (Group C)

Respondents were invited to comment on contributions to support made by their social network. The majority of references were regarding the role of family but some clients also discussed the role of friends, other professionals and partners.

Family

Generally women in Group C did not have identified problems. Therefore comments about sources of support arguably reflect support available in *less* problematic parenting situations than those described by clients in Group B. However, many Group C clients still reported families as not having the knowledge to help, not being interested in helping or exerting a negative effect as reported in Group B.

Three Group C clients explained that either they had no family (n = 1) or their family lived in a different part of the country so that help was not an option. One mother reflected that such an occurrence was by no means unusual today.

(Client 65)

'My family don't live here, they live in Luton, Wales and all over so I haven't got family, and I'm sure a lot of us are like that we move around these days, we don't live close.'

The descriptions given of 15 further clients demonstrated that proximity of family was not always perceived as supportive. Some mothers commented on more than one aspect of family involvement.

Five mothers remarked that changes in child rearing practices between the generations limited ability of family to help.

(Client 11)

'... my mum's been through it a long time ago and things change, its all right your mum saying ah well we used to do this with you and it was a long time ago and they don't always remember accurate.'

Two clients observed it was not always feasible to talk to family members because of the nature of the problem.

(Client 40)

'... sometimes you can't talk to family about certain issues.'

Some (n = 5) respondents remarked that poor family relationships precluded positive contributions. Three women described no viable relationship between family members.

(Client 97)

'Family don't want to know, that is my side of the family ....'

Difficulties arose for two clients because the didactic approach taken by family members.

(Client 33)

'I mean you've always got your mother-in-law or your mum who's always saying I think you should do such and such or why don't you try such and such and you're just torn down the middle.'

Four further clients reported their family could not help because they did not understand problems experienced by the mother.

(Client 34)

'Nobody understands, no they don't understand we have never been a very close family in any case.'

Friends

In considering the role of friends, similar issues of lack of knowledge and difficulty in sharing personal problems arose in both groups.

Women in Group B had problems with their health or child care that were not common features of parenting. Consequently, it was observed by some Group B mothers that the *uniqueness* of their experience set them apart from the support of friends because friends did not have insight into their situation.

Therefore, it was interesting that, though generally mothers in Group C *were not* apparently experiencing particularly uncommon parenting or child care problems, some still perceived friends as limited to in their ability to help. Six women in Group C observed that friends may not have the knowledge to provide support.

(Client 33)

'We ring each other up and say do you know what happened to me today and you tell her all the terrible problems and she says yes I know but what do we do about it? I mean we sympathise with each other and we support each other but often we don't have the answers.'

One further woman felt reticent about using friends to unburden herself.

(Client 40)

> *'Well all my friends live a distance away and we don't see each other that often, they're all there, they've got families so when they come you don't want to bring up problems in front of them.'*

Other professionals

Clients in Group C, in contrast to Group B, were unlikely to be in regular contact with other professionals. However, where comparisons *were* made in Group C between HVs and GPs some similar points were raised. Chiefly, HVs had more time to spend with clients and demonstrated more interest in mothers' concerns.

Five mothers in Group C compared the service that they received from the HV with that received from their GP. Two clients expressed the opinion that HVs possessed the skills that mothers needed *in addition* to having more time than the GP.

(Client 71)

> *'... how can I put this ... if you go to the doctor, the doctor is in a rush to carry on doing his duties and doesn't have time. You go to see the doctor about a nappy rash and he won't give you the time of day because he is too busy and he has got too many calls, so its unimportant to him, very unimportant, he hasn't got time to worry about so you are straight in straight out, whereas your health visitor it doesn't matter whether it is nappy rash, colic, spots on his face what ever, it is important to her and that's her job and she will sit with you and she will explain all what she thinks you should do ....'*

The remaining three clients reported discussion with the GP was too narrowly focused. One mother perceived discussions with her doctor was primarily concerned with her drug regime rather than talking to *her*.

(Client 50)

'... I don't think he really understands really how ill I have been, sort of the root of the problem, its a case of going in we'll talk about tablets really not me, its the tablets and then he'll write a prescription.'

In the second case the mother perceived the GP's interest to be limited to the baby. It should be noted that midwives and HVs other than the mother's current one were *also* included in the description of professional interest centred on the baby.

(Client 40)

'Well mainly the GPs and midwives and health visitors they all seem basically be interested in babies ....'

The third mother reported conflict with her GP because she was anxious about her son being immunised. The client contrasted this with her HV's attitude of being willing to support *her* decision in addition to acting as her advocate with the GP.

(Client 51)

'She gave me support in the immunisation because she said if you decide not to do any more she'd support it. She was real nice about that ... I know if I went to my doctor and said I don't want him to do any more he'll nag at me to make sure he'll get it into me, that I'd have to. But she said if you decide not to give him any more then that's it we won't say nothing more about it.'

Partners

Fewer women in Group C than Group B discussed the role of partners in supporting them. This might be explained by the occurrence of established problems in Group B. Comment on the support given by partners might be considered *more* likely to occur in situations where there *were* problems than in less difficult situations where arguably support from partners might be less of a concern or need of the mothers.

Two themes, partners also being under stress and partners not understanding the mother's situation, were shared by both Groups. The issue of lack of support due to tensions

between partners raised by two clients in Group B, was *not* mentioned by any Group C mothers.

Most women (n = 23) in Group C were living with a partner. Five mothers provided comments about the involvement of partners in terms of support. Two mothers stated their partners had limitations as to the support they could give, but for different reasons. One client and her partner observed that in their experience in the transition to parenthood the father was just as likely to feel the need for support as the mother.

(Client 6)

> *'It was the first week when Ryan was born and I came out of hospital Bernie* [partner] *was with me all the time I was in hospital so he only got the same amount of sleep as me because he was with me all the time, and when the visitors came it was all my friends and it was their kids and Bernie sat in a room with six or seven lasses and its his own home as well he needs his privacy and there was always people ringing up and coming down and it was all attention for me, and he was tired and there was one night he started crying .... You think its just the women but men go through it as well.'*

The second client explained that her partner's mental health problems precluded him from being able to offer any support to her.

(Client 35)

> *'... I can't speak to him. He suffers with depression.'*

Two mothers felt their partners' lack of understanding of their situation made it difficult for them to help.

(Client 34)

> *'I mean he tries to be understanding and helpful but its hard for him to understand a woman's problems like that.'*

The final client in this group explained that the issues to do with the children and home were viewed as her responsibility by her partner.

(Client 71)

'the kids and the house are my problems.'

Summary

Both groups gave similar descriptions of the negative consequences and the limited abilities of partners, families and friends to help. The role of the GP was not noted as frequently in Group C as Group B. However, the lack of time available to the GP and a perception of more interest being shown by the HVs were noted in both Groups.

Category - 'Being there' (Group C)

Eighteen Group C mothers commented on the contribution of communication skills and personal qualities of their HV in providing support.

<u>I can talk to her</u>

Clients' remarks about feeling relaxed with the HV, the HV as a confidant and the absence of another person to talk with were raised in similar terms between the two Groups but noted more frequently in Group B.

Three mothers in Group C commented on the ease with which they felt they could talk to the HV.

(Client 18)

'I can speak to Kirsty [HV], *like if I feel let down or depressed. I won't feel daft or anything.'*

Another client appreciated the fact that the HV had taken time to talk with her about her problem.

(Client 93)

'She talked it through with me. She was not in a rush.'

The mother's appreciation of being able to talk about herself was a feature of Group B but was rarely mentioned by mothers in Group C. Two mothers highlighted that the HV was someone who allowed them to talk. They both commented on the value of being able to talk to someone who was interested in *them*. In both cases the problem was concerned with the mother rather than a child.

(Client 40)

> *'Well as soon as she came in she said I am not interested in baby, I want to see you, and that was quite good actually because it was the first time that anyone has ever said that in that way, because all they generally do is think of baby, but it wasn't, it was for me.'*

Another client appeared to perceive the HV as a person to whom she could unburden herself.

(Client 71)

> *'Well I think when you are a mum for whatever time, second time or third time, you have feelings of insecurity if you like because you have just had a baby, there might be a few problems with yourself or there might be a few problems with the baby, just to have someone that is calling round and you can tell those difficulties to however trivial I know that I can tell Sue whatever the problem is ....'*

Like a friend

The notion of friendship was raised by six mothers in Group C. Most of these descriptions used the word friendly in relation to the HV. The idea of friendship was different between Groups B and C. In the latter the concept was weaker as most mothers who mentioned the notion used the word 'friendly' in talking about the HV. By contrast most mothers in Group B used the term 'like a friend' which implied the presence of a relationship rather than merely a description of an attitude.

(Client 34)

'I don't like class her as a friend but she is like friendly enough towards me to be a friend, we get on you know, she likes me and I like her.'

One client explained that this enabled her to talk to the HV.

(Client 23)

'She was very friendly, I feel I can ask her anything not necessarily things to do with the baby just general problems.'

However, one respondent used a stronger description which suggested that the HV was not just friendly but like a friend to the mother.

(Client 137)

'... because she seems so friendly, so open, you could just class her as friend, you don't see her as a person coming to check a baby and check you over, you know.'

<u>She understands</u>

Both groups also offered approximately the same descriptions about listening and understanding.

The notion of being understood as an element of support was raised by three women in group C. In two cases, the client provided a clear description.

(Client 137)

'To me I know somebody is there to talk to who understands.'

The third client referred to this concept more obliquely. This mother appeared to perceive the HV as a person who could increase her confidence in making decisions.

(Client 33)

'I always feel as though she is very supportive maybe not over anything specific but I always feel she is on my side .... I think you just need them to be there and just say it doesn't matter just do what's best for you.'

She listens

Five mothers regarded preparedness of the HV to listen to them as an aspect of support. Three mothers commented that the HV either listened in a unique way or that there was no one else in their social network who would listen.

(Client 35)

'I am the one who has to listen, so when I get listened to it's different and it's good, it's a good feeling.'

Generally, five respondents observed that no one else was available with whom they could talk in the same way.

(Client 71)

'... she [HV] *does something different because she can give you advice and she will listen and friends and that don't really, in my case any way.'*

Summary

The 'caring' theme was absent in Group C. 'Caring' involved descriptions from women that they believed the HV cared about them, could be trusted or was a dependable person ready to help them. The absence of this level of description in Group C together with the weaker concept of friendship suggests a more involved relationship between HV and client in Group B.

Category - 'Lifting a weight' (Group C)

The eight women in Group C (n = 24) who described an outcome from the visit of the HV did so in terms of feeling better.

Feeling better

While these Group C women reported change ('feeling better') due to the intervention of the HV these reports were more diffuse than in Group B. Although mothers reported 'feeling better' in Group C they did not provide the accounts of more *specific* outcomes in the way Group B did.

Two mothers used the word 'relief' to describe how it felt to have spoken with the HV. This appeared linked to fact that they had found someone willing to listen to them.

(Client 35)

> *'I don't see nobody to talk to, I really wanted to talk to somebody about it and I felt a great sense of relief that somebody was there and somebody was listening to my problems about the way I felt and what I thought it was doing to me.'*

Three further clients used different phrases, but they all suggested a sense of relief.

(Client 18)

> *'it took a lot of weight off me.'*

(Client 33)

> *'... a feeling that everything is going to be okay.'*

(Client 40)

> *'it's nice it gets it out of your system.'*

Three mothers stated they 'felt better' after speaking with the HV. One mother explained that this was due to the reassurance that she gained from the HV verifying the care and progress of her child.

(Client 6)

> *'She reassured me that there were no problems with the child, she reassured me, I feel like I'm looking after him well that I'm doing everything okay.'*

The remaining two clients reported 'feeling better' because the HV was a dependable source of advice for their problems:

(Client 71)

> *'I have shared my problems with somebody, and then she helps me sort those problems.'*

Summary

Both Groups provided descriptions of feeling better after the HV's visit. As women in Group B appeared to be experiencing more distress than Group C there may have been a difference in the quality of 'feeling better' experienced by both Groups. Group B may also have had more opportunity to 'feel better'.

Two themes, 'making a difference' and 'coping' recorded in Group B did not arise in Group C. Both these themes described the role the HVs played in identifying and helping women deal with problems. The responses of Group B mothers appeared to suggest that the HV's visit not only made them *feel* better but also positively affected outcomes to problems. Arguably this might suggest that the visit of the HV was more crucial in helping the client maintain her well-being in Group B.

CHAPTER SUMMARY

Six categories emerged from the descriptions of support provided by mothers in Groups B and C. Therefore, according to these clients, support was multifaceted. Individual variation regarding what support meant to the women was demonstrated in the range of categories included in their description of support.

A major difference between Group B and C was that the former group apparently shared a concept of support that included *all* categories whilst the latter included mothers who nominated between one and five categories as constituting support. This suggests that although support was viewed as containing a variety of elements there was not a fixed number or type of elements that had to be included before support was identified by the women.

Group B was further distinguished by the predominance of psychological issues with which clients were currently coping. This was in addition to any child care problems they might have. By contrast, reference to issues in Group C generally concerned problems of child care/management. In addition Group B clients referred more precisely and more frequently to the *benefit* that had accrued from the support offered by the HV. It may be that psychological difficulties predispose clients both to need and to use all elements of support and to benefit in a way that is not relevant to other mothers.

CHAPTER 11

DISCUSSION OF THE FINDINGS FROM THE HOME VISITS

The current study seeks to add to the description of the work of the HV by illuminating the impact of her work during home visits; the following aims were identified (see Chapter 4.1):

- to identify clients' recall of issues discussed
- to examine clients' reports of advice/information from health visitors
- to examine clients' reports of use of this advice/information.
- to describe clients' accounts of value of this advice/information
- to identify the meaning of support to clients

This chapter attempts to integrate the quantitative data (see Chapter 8) and qualitative data (see Chapters 9 and 10) and discusses these findings in the context of issues raised in the literature review of home visits (see Chapter 2).

Previous descriptions of home visits have been based on HV recordings (Marris, 1971; Clark, 1973) or accounts of observers who were present during a domiciliary visit (Watson, 1981; Kendall, 1991). In addition, researchers have asked clients to recall issues discussed (e.g. Quine and Povey, 1993) although problems were noted with retrospective design (see Chapter 2.4.1). In addition, the question construction of some studies may have biased mothers towards reporting issues concerning children (see Chapter 2.4.1). The current study presents a more detailed report of issues discussed during home visits than hitherto available. Moreover, it provides the opportunity to compare the recording of issues by HVs with the recall of issues by clients.

Section 11.1 Recall of issues

The HVs recorded 910 issues discussed during the 149 visits. Clients recalled just under half (n = 444, 49%) of these issues but this proportion differed according to type of issue discussed and type of visit. Clients' recall of issues in three categories: feeding; development of child; illness/minor ailments, was approximately two thirds. Just over half

the occasions that immunisation was recorded by HVs were recalled by clients. Recall by clients was less than half for issues in the remaining four categories (management of child; services; other and maternal). Maternal issues appeared least likely to be recalled by clients (33.5%).

It is not clear why there should be this apparent difference in recall between types of categories, although with regard to issues in the maternal category there *was* an apparent distinction between the types of issues that were recalled and those that were not. Certain topics, usually concerned with physical health matters (e.g. mother's physical health, family planning, postnatal examination) appeared to be associated with a low rate of recall. By contrast, issues in topic areas that focused on psychological health or social issues (e.g. mother's mental health, bereavement, housing) appeared more likely to be recalled.

In addition recall of all issues discussed was noted to vary between types of visit. Across the three different types of visit, clients remembered discussing on average between a third and half of the issues recorded by HVs. Clients in the primary visits group remembered the smallest proportion of information received of all the groups. The fact that this difference was not significant once the amount of information *given* to clients was accounted for using analysis of covariance suggests that the amount of information received exerted some influence on recall. However, as noted above some categories had a higher rate of recall than others. Therefore, it may be that some differences in recall between the visit types might be accounted for by the different issues that were discussed.

The current finding is supported by previous research that reports an association between amount of information given and proportion of information recalled (Ley, 1993). This issue may have implications for HVs in terms of the sheer amount of information they offer clients. HVs might usefully negotiate with clients the issues that are *most* important to discuss during a given visit, to reduce the burden on memory. Moreover, prescriptive guidelines by Trusts about issues which should be discussed during certain visits may be of little value if they encourage a barrage of information sharing from the HV which cannot be assimilated by the client.

In addition to the *amount* of information received, previous research shows that communication strategies have been shown to affect the amount recalled (Ley, 1993). Therefore, given the number of issues they discussed HVs may need to consider the way that such information is communicated. Approaches which include stating the importance of an issue, explicit categorisation of information, repetition and specific examples of advice rather than general statements are associated with greater recall (Bertakis, 1976; Ley, 1979).

These findings need to be interpreted with caution as HVs *may* have felt constrained to offer more information than usual or may have consciously or unconsciously over-reported the number of issues discussed. Over-reporting would lead to inaccurate calculations of the number of issues *not* remembered by clients. However, given that the HVs knew that clients would be asked what was discussed, there would be no incentive to over-report deliberately.

It was noted in the literature review that linking clients' reports of home visits with outcomes arising from such visits is problematic due to poor reporting of responses and problems with question construction (see Chapter 2.4, 2.5). In addition, most studies did not attempt to confirm that advice/information had been used (see Chapter 2.6). One aim of the current study was to examine the outcomes of home visits in *specific* terms with regard to the most important topic discussed. This included: client's recall of discussion of all issues, the use of advice/information and satisfaction with the most important topic.

Section 11.2 Clients' description of the most important topic

Previous researchers had assumed (Clark, 1973; Watson, 1981) time spent on a topic indicated whether it was the *main* topic discussed. The current study attempts to clarify the issue of importance in terms of the *client's perspective* by asking them what they viewed as the most important topic discussed. Mothers in the current study most frequently reported issues in topic areas concerning management of the child, feeding, maternal, and development of the child as most important.

This is particularly interesting given the current study's findings that management and maternal topics were frequently not recalled. Clearly *some* topics within these categories

were of concern to clients. The importance of maternal issues was particularly observed in the 'issue visit' clients where it constituted a quarter of most important topics. The majority (n = 18) of maternal issues chosen as the most important reflected mental health or social concerns. Therefore, whilst the current study found that mothers predominantly chose issues in topic areas ostensibly focused on children, maternal (especially psychological) topics represented a sizeable minority of the topics reported as most important.

This is in contrast to an earlier study (Cameron, 1994) which reported diet, baby's health and immunisation as accounting for three quarters of the subjects chosen as most important by the client. Mother's health was selected by only 11% of the sample (n = 45). However, as no definition of 'mother's health' is given in Cameron's study it is not possible to identify whether this focused on physical or psychological concerns or both.

Differences between Cameron (1994) and the current study may reflect apparently different economic circumstances between the samples. Moreover, Cameron's sample was restricted to primiparous mothers, over 70% of whom had a child under four months. It might be assumed that diet and immunisations might figure highly with first time mothers with babies in an age range that covers weaning and commencing the immunisation programme. The current study benefits from the inclusion of multiparous clients with children with a spread of ages. It might be assumed that the current study represents a more general range of health visiting clients. Consequently, the findings in the current study might represent a more typical account of health visiting activity.

Section 11.3 Clients' prior knowledge of advice/information

Kendall, (1991) observed that advice was 'often' given by the HV in areas where the mother either had *some* knowledge or where the mother was already taking action. A later study produced ambiguous findings regarding this issue (Cameron, 1994). If mothers *know* the advice/information this might reflect insufficient knowledge of the HV, a didactic approach by the HV or both. Accordingly, this issue of prior knowledge by the client was specifically examined in the current study. The current study reports a quarter of the sample (n = 36) stated that, with regard to the most important issue, the advice/information

received *was* new. However, other cases, where the client knew some or all of the advice/information, did not necessarily indicate that the discussion was irrelevant to them.

Nearly a fifth (n = 28) of those who recalled discussing an issue with the HV stated that they knew *all* the advice/information. It was evident from responses to the follow-up question regarding *why* they had talked with the HV that the largest group of these participants (n = 12) used the HV to check information in a variety of ways. They checked that a proposed action by the mother was correct, cross checked information received from other professionals with the HV, checked that a situation was normal or clarified information. A further seven mothers gained reassurance from the HV by confirming either that there was no problem and/or that the mother was managing the situation appropriately.

In the case of mothers who knew *some* of the advice/information many were again checking information (n = 21), or seeking reassurance (n = 5) that all was well regarding some aspect of child care or health. In addition, 19 clients in the 'knew some' group reported discussing an issue to get *more* information. These findings suggest diverse uses that clients may make of the HV in looking after their own or their children's well-being. The current study suggests that HVs are used as a reference point for mothers in addition to being a source of new advice/information.

Most comments were favourable when the mother knew all or some of the advice/information, but not in all cases. Where the discussion had been raised by the HV most (n = 11) clients knew *some* of the advice/information but rated it fairly or very helpful and fairly or very important. This contrasted with cases where the discussion had been raised by the HV (n = 9) and clients knew *all* of the advice/information. Four mothers made favourable comments about their discussion, but the majority (n = 5) gave neutral or negative helpfulness and importance scores. This confirms the importance of HVs *establishing* that a client is actually interested in discussing an issue rather than assuming discussions on any issue will be welcomed.

This importance is emphasised by the current finding that HVs initiated over two thirds of topics (67.9%) during home visits. This contrasts with the lower figure of 57.2% reported

in previous research (Clark, 1976). Clark (1976) suggests that initiation of topics during home visits may be interpreted as a measure of dominance exerted by the HV. Therefore, this *might* be taken as evidence that clients were forced into discussions of no interest. However, introduction of a topic does not *necessarily* imply that the there is a subsequent lack of negotiation between the parties or that the client is unable to set their agenda. Without details of the interactional process during the visit it is not possible to assume that the proportion of issues raised by the HV indicates they dominated the interactions which occurred during home visits.

Section 11.4 Use of advice/information by the client

Generally, studies have not attempted to verify whether clients have actually used advice/information given by the HV. One exception is Cameron (1994) who reported that 44 of her sample (n = 45) said they would use the advice received during the last visit. However, details of topics were limited. Two mothers recorded an issue to do with themselves, 25 clients mentioned feeding, 12 listed immunisation and the remaining six topics were not reported. It has already been noted that Cameron's sample was limited to primiparous mothers, usually with a baby under six months. This may explain why the clients in the current study refer to a far wider range of topics about which they will use the advice/information received. The current study also shows the value that clients placed on the HV as someone to *consult* about issues in addition to being a repository of new information. Client's provided descriptions of the outcome of discussions in terms of referrals to other agencies, receiving reassurance, and discussing feelings.

Section 11.5 Clients' report of satisfaction with the advice/information

It has been noted earlier (see Chapter 2.6) that descriptions of clients' satisfaction with the health visiting service have been restricted in what they demonstrate about particular aspects of home visits. The current study has examined a specific element of home visits (advice/information) and explored the client's satisfaction in terms of helpfulness and importance with this aspect of the HV's service. By asking the client to choose what *they* considered the most important topic discussed the current study may have avoided biasing the client's responses to issues concerned with children.

Generally, the current study reports very high satisfaction rates in terms of ratings of helpfulness and importance. As important is the client's explanation of *why* they reported a particular level of satisfaction. Most descriptions of helpfulness indicated discussions with the HV resulted in either the client increasing their knowledge, being helped in the management of a problem, being reassured (usually through the HV providing clarification of an issue). A smaller group of responses suggests the effect of the discussion was helpful for the mother at a personal level. These explanations of helpfulness show outcomes for clients linked *with* a specific recent visit of the HV. These data add to our understanding of outcomes for clients of home visits from the HV.

In addition, some understanding of the value of this advice/information to clients was elicited from mothers. This is particularly pertinent as statements about helpfulness are strengthened if the issue is also perceived as something *important* to the client. A minority (n = 12) of clients stated that the advice/information was neither important nor unimportant or was very unimportant. These mothers either knew the advice/information given or considered it as trivial. However, the majority of mothers *did* regard the advice/information as either fairly or very important which suggests that generally this group of clients regarded discussions as relevant and welcome.

Questions about helpfulness and importance produced a total of 17 clients who gave a neutral to negative response regarding helpfulness or importance or both. It might have been expected that there would be congruence between helpfulness and importance scores but this was true in only three cases. Nine mothers who found the advice/information neither important nor unimportant or very unimportant said that the advice/information was *fairly helpful.*

In addition, five clients said they felt advice/information was important but selected neutral (n = 4) or negative (n = 1) helpfulness scores. The reasons given for these responses were that they knew the advice/information or the advice/information was limited. It was noted that seven of the 17 discussions which elicited neutral or negative responses were initiated by the HV. These findings suggest the relevance of HVs *establishing* a need for any discussion with a client. In addition, HVs need to ensure that they have an adequate knowledge base to match client's needs.

In addition to the 17 clients who selected a neutral or dissatisfied response, eight clients recalled no discussion. The fact that clients did not recall any discussion does not necessarily imply dissatisfaction on their part. Lack of recall did not appear to result from a perceived bad experience with their own HV or with the health visiting service. It is interesting to note that mothers who were negative in some respect about the discussion with the HV were still able to *recall* the discussion and provide comment. It must be some cause for concern if clients find the HV's visit so lacking in impact that they recall no details of the discussion, especially as HVs in the current study might be considered particularly enthusiastic and skilled given, the nature of those who volunteer for research projects (Sapsford and Jupp, 1996). The 'no recall' group were characterised by having no apparent concerns regarding their own or their child's well-being, and in three cases not perceiving a need for any health visiting service.

Section 11.6 Support given during home visits

The focus of the current study is clarification of the work of health visiting through reports of clients' perspectives. It has been noted that several previous studies (see Chapter 2.4) provide descriptions which suggest that the HV's role is primarily as an advisor regarding children. The extent to which this role also incorporated an element of supporting mothers and parents was less clear from these studies. There are three main reasons why an exploration of whether support is offered by HVs is of interest and relevance.

First, is the government initiative which, amongst other things, reportedly seeks to shift the HV's role from dealing with problems to helping individuals avoid them in the first place (DoH, 1998b). The phrase support is used frequently but with little clarity about what supporting families actually means. Second, it has been argued that the concept of social support has for a number of years been recognised as a form of personal interaction that can confer physical and psychological benefits for the recipients (see Chapter 2.7). Third, several studies *have* referred to support being offered by the HV and received by the client (Clark, 1984; Pearson, 1988; Colliety, 1989; Watson and Sim, 1989; Kendall, 1991). However, only one author (Pearson, 1988) has provided any description of what this concept might entail. Even so, Pearson did not distinguish between support received by clients from their social network and from the HV. In addition, her sample (n = 21) was restricted to primiparous mothers.

Section 11.7 Identification of support by clients

This study provides for the first time an examination of support across a broad range of clients in terms of parity and ages of children. Eighty (54.0%) clients stated that they had received support on the previous visit. These findings are in contrast to much lower frequencies of support reported by other researchers (Clark, 1984; Colliety, 1989; Machen, 1993). However, these studies reported responses about support in relation to a question regarding the mother's perception of the *role* of the HV. Such question construction did not necessarily cue the clients to report what their *experience* had been. Moreover, previous studies did not specifically ask clients about support, which may account for the lower frequencies of reporting.

Two further studies (Watson and Sim, 1989; Kendall, 1991) focused on the previous visit from the HV. Both incorporated the HVs' perceptions. Watson and Sim (1989) reported 15% of clients stated they had discussed issues of support compared with the HVs' recording of 20%. This study *did* report the client's experience but the low figure of 15% reported by clients might have arisen for two reasons.

First, 38% (n = 38) of the sample were described as Bengali clients. The authors imply that communication between HV and client was not unproblematic as the HV always aimed to take an interpreter on a visit, but this was not always possible. It is conceivable that communication difficulties might impact on either the ability of HVs to offer support or clients to receive it.

Second, support for the mother/family is described (Watson and Sim, 1989, p 216) as 'the *subject* of 20 discussions' [my italics]. The aim of the study was to examine the match between perceptions of the HV's and the mother's views regarding the *purpose* of the visit by the HV. This was achieved by comparing the description of topics discussed provided by the mother and HV. This may have led to under reporting since the current study found that support was not necessarily a topic that was talked about but arose as a consequence of a discussion or was described as a perceived quality of interaction or an expectation of help.

Kendall (1991) reported HVs identified 29.3% mothers requiring support, in contrast to the clients of whom 21.3% recorded the need for support. However, agreement *between* HVs' and clients' perceptions of the need for support was found in only 4% of cases. Whilst enquiries about a *need* for support do not indicate whether support was given, such a mismatch raises questions about whether there is shared understanding between HVs and clients regarding the meaning of support. The current study does not attempt to comment on the HV's perception but provides illumination of how the *client* might perceive this concept. An understanding of the client's perspective is vital if services are to be appropriate.

Although the majority of clients in the current study reported support as an aspect of the HV's visit a sizeable minority (n = 68, 45.6%) did not. It is not possible to extrapolate from the current study how the responses of those who said that support had not been an element of the visits should be interpreted. However, there are two main explanations that might account for this. First, the client may have failed to recognise support was offered, or regarded that offer as inappropriate (it was noted earlier [see Chapter 2.7.2] that offers of support may not always be appropriate). Second, HV activity on the home visits *may not* have included elements that might be defined as support. This might reflect a deficit of some kind on the part of the HV such as the failure to recognise a particular need, or insufficient communication and empathic skills. Alternatively, elements of support may have been unnecessary for that particular visit.

Section 11.8 The meaning of support to clients and comparisons with the theoretical literature

A central aim of the thesis has been to clarify any distinctive contribution made by the HV. Consequently, the analysis of the support data focused on clients in Group B (n = 13), 24.8%) and Group C (n = 24), who said that support they received from the HV was unobtainable elsewhere. Arguably, for these clients, support can be *uniquely* attributed to the HV. The importance or otherwise of this contribution must lie in the value attributed to it by clients.

Components of support and the outcomes resulting from being given support were most fully described by Group B (n = 13). These clients were characterised by recounting

specific problems of at least several weeks duration. Practical advice, information and empathic skills of the HVs were noted by all these women. Often the visits of the HV were reported as instrumental in avoiding or alleviating a crisis. Arguably, this group of women recounted a type of involvement by the HV that could be viewed as therapeutic - that is, facilitating a recovery to well-being or helping the mother to maintain her ability to cope with a situation. Group C clients (n = 24) by contrast were characterised by a more restricted description of support. Not all clients mentioned all categories. For some of these clients it was the reassurance given by the HV that she would be there *if* a problem arose.

A key question in examining these responses is whether the support described by the clients in the current study reflects descriptions of social support (see Chapter 2.7). Previous research into the role of the HV has noted the presence of support but failed to explore the meaning with the client. By contrast, this study provides detail which allows some comparison to be made between elements noted in theoretical approaches and those raised by the clients in this study. The six different types of support described by researchers (Wortman, 1984; Cutrona and Russell, 1990) can be compared with the descriptions of support that clients provide in the current study (see Figure 11.1).

Figure 11.1: Comparisons of taxonomies of social support with emergent categories of support in present study

Taxonomies of social support	Emergent categories in current study
Emotional support - allowing the person to feel cared for	'Being there': The importance of health visitors' empathy and caring.
Social integration or the sense that the person is part of a network	'Safety net': Having someone to turn to should the need arise
Bolstering of an individuals self esteem	'Lifting a weight': Linking outcomes with the visit from the health visitor
Offering advice/information	'She knows what she is talking about': The role of advice or information in support
Providing information that the individual is part of a network of reciprocal help	not mentioned*
Instrumental aid	not mentioned

* = professional support is reported (e.g. Stewart, 1993) as *unidirectional* rather than reciprocal

The similarity between themes in the current study and descriptions in the theoretical literature suggests an apparent congruence between taxonomies of social support and the support which was identified by the clients in the current study. Further, the two major theoretical approaches (the 'buffer effect' and the 'main effect' - see Chapter 2.7.2) which explain how social support achieves an effect, may be used to comment on the difference between descriptions of support provided by Group B and Group C.

Problems existing over time or a history of a problem which still led to anxiety on the part of the mother were features of all mothers in Group B (n = 13). By contrast such experiences were recounted by a small proportion (12.5%) of Group C (n = 24). Moreover, mothers in Group C reportedly valued the HV *in case* problems arose. Most mothers in Group B *were experiencing or had experienced* problems which had been helped by HV. This might explain the lack of reference by Group B clients to the *potential* use of the HV described in the 'safety net category'.

As previously described (see Chapter 2.7) the buffer effect of social support is operational only in situations of high stress (Sarafino, 1990) whereas 'the main effect' can be effective irrespective of whether stress is present (Gottlieb, 1987). It might be posited that the support offered by HVs to Group B clients had a buffering effect while that offered Group B was more representative of the main effect.

Both Groups B and C describe positive outcomes of the HV's work not only in terms of information received but the way the mother *felt* as a result of the visit. Descriptions are provided of reassurance, increased confidence, feeling better and having anxiety alleviated. This reflects the findings of other researchers (Quine and Povey, 1993; Jessice and Watkins, 1995) who also report an improvement in affect as a consequence of the HV's visit. However, as previously discussed, both these studies asked about multiple visits some of which had occurred years previously. The current study allows more precise reporting by clients due to the recent nature of the HV's visit.

Descriptions of support perceived by clients adds another dimension to previous descriptions of client perceptions. There has been national comment regarding the

invisibility of primary care nursing (DoH, 1999c) and specifically the limitations of present methods of recording HV activity (DoH, 1998b, p 11):

> '*Currently health visitors are asked to record the number of contacts but this does not reflect the nature or intensity of the contact.*'

The current study provides detail of elements of the HV's skills and of the impact of that service in a way that merely recording number of contacts may have a limited ability to achieve. Consequently, this study goes some way to highlighting the possible importance of some of this unrecorded information and adds to the available knowledge about work of the HV during home visits.

Many previous descriptions of the content of home visit have indicated that issues to do with children predominate (e.g. Moss et al., 1986; Colliety, 1989; Cameron, 1994). The current study is no exception, with most issues being recorded by HVs as concerned with children. Furthermore, when clients were asked to select the *most important* item discussed during a visit, issues concerned solely with children were chosen by 70.2% (n = 99) of the sample. Such findings might suggest that the HV has a limited impact or relevance for most mothers in terms of their own well-being. However, it may be that issues ostensibly primarily concerned with children do not preclude an effect on the *mother*. The descriptions of support *in addition* to descriptions of issues apparently focused on children's needs suggest these discussions may include responding to a mother's needs.

In summary, the focus of this study on a home visit by the HV seeks to clarify issues concerned with the impact of such a visit. It attempts to link the client description of content of the visit with an examination of outcomes from that visit. Outcome is defined in terms of recall of issues, use and satisfaction with the most important advice/information. In addition, the study provides an exploratory investigation into the existence and meaning of support to clients.

This study does not claim that recall of advice/information is an unproblematic index of a satisfactory health visiting service. The findings show that people may recall

advice/information *and* be dissatisfied with that advice/information. However, if (as seems evident with health visiting) advice/information giving is an aspect of a particular service it is legitimate to examine the outcome of that activity in terms of recall. Client recall might be considered a necessary but not sufficient outcome of effective health promotion. The finding that eight clients recalled *no* discussion suggests that recall by clients cannot be assumed. However, the current study found that most clients recalled several issues and reported the discussion regarding the most important item discussed as helpful and important for a variety of reasons. Moreover, the study suggests that these clients were using the HV not simply to gain more advice/information but as a resource to consult on issues of concern.

In addition, these discussions appeared a source of support to many clients. The implication of this support varied according to the client's situation but are described in terms of increasing the mother's well-being. These descriptions appeared comparable to those in the theoretical literature on social support. The findings also suggest that support was an aspect of interaction with the HV that was not always apparent from the description of most important topic discussed.

CHAPTER 12

DISCUSSION OF THE STUDY FINDINGS

This chapter identifies and discusses keys issues arising from the current study. Implications for health visiting in terms of practice, education, management and research are discussed. Some issues are specific to work in the CHC or during home visits and are considered under the relevant headings; other remarks apply to both activities. It should be noted that the ideas discussed below derive from both studies. They cannot be assumed to represent all health visiting activity. The implications that are discussed should be viewed within the context of the study. Local health visiting perspectives elsewhere need to be considered when assessing the relevance of these conclusions.

Section 12.1 Implications for practice

The child health clinic

Responses of clients in the current study suggest the following. Child health clinics address two needs identified by the consumer: an opportunity to weigh their child and an advisory service (see Chapter 5.4.1). The former does not imply a need for the latter. This raises the question of whether it is necessary for children to be weighed by the HV or other staff member. Weighing by the HV would appear a dubious use of her time and may enforce unnecessary passivity on the part of the mother. Studies have suggested that weighing by the HV affords an opportunity for her to give advice (Acheson, 1962; McIntosh, 1964; Steiner, 1977). However, a CHC system which necessitates an encounter between the client and the HV may encourage enquiries and discussions by the HV that are not required from the *client's* perspective (see Chapter 6.7.1). The current study suggests that mothers will use the HV if they so wish. However, the study also suggests that the HV's advisory role *is* necessary and valued from the consumer's perspective.

This is of some interest given the proposed changes in the HV's role. A model has been suggested whereby HVs will manage teams including nursery nurses and community workers (DoH, 1999a; DoH, 1999b). These teams would be responsible for community level initiatives in addition to work with individuals. Further, it has been argued HVs should focus on community level work and delegate work at an individual level (CPHVA,

2000). In this model, CHC work might be considered suitable to delegate to staff other than HVs.

Hall (1996) notes that the concerns and preoccupation of parents must be considered in the service design. Further, he suggests that even if evidence of effectiveness is scanty, services perceived as valuable by the consumer should not be too readily dismissed. The current study found the importance of talking with the HV was associated with real concerns and anxieties by the mother (see Chapter 6.2.1). The findings give support to Orr's observation (1980, p 65):

> *'It is in the utilisation of well baby clinics that the consumer can best exhibit demand for the health visiting service.'*

Therefore, any proposed substitution for the HV within the CHC should consider the knowledge required to ensure that a replacement worker would be able to respond to mothers' concerns adequately.

The home visit - the relevance of support

Half the home visit group identified support as an element of the visit. A quarter of clients identified this support as a *unique* contribution by the HV (see Chapter 10). Descriptions focused on aspects of communication and interpersonal skills such as listening, demonstrating interest and empathy but also included advice and information. Support appeared similar to concepts outlined in the theoretical literature (see Chapter 2.7). This similarity between clients' accounts and theoretical descriptions of support is important if support is to be recognised and valued as promoting positive client outcomes. Previous consumer surveys have highlighted the advice/information role of the HV but provided minimal detail or understanding of other aspects of health visiting such as support (see Chapter 2.6).

In the current study, feeling supported either arose as a result of advice/information, or was perceived as a separate quality. This suggests that advice giving may itself be supportive. It also provides evidence of interactions between some clients and HVs that reflect skills focused on improving and maintaining the client's coping abilities. Of particular interest

was the group of clients who described what appeared to be a therapeutic level of involvement by the HV (see Chapter 10.2). Although small in number, this group apparently represented a particularly vulnerable group of women. Those clients who received interventions from other workers *still* identified a unique and valued contribution from the HV.

This is of importance as it is suggested that there has been an expansion in the number of workers who can offer many of the skills offered by HVs at the individual level. It is suggested continuing to work at the level of the individual: '... may not be recognised as the role of the "modernised health visitor"'. In addition, the value of work with individuals is somewhat diminished by the statement that HVs may choose to continue working with individuals because it represents their 'comfort zone' (CPHVA, 2000).

The current research provides some evidence that HVs are offering *specific* professional approaches to working with clients. Further, the difficulties described by some clients appeared complex and not fitted to a public health community approach. In addition, the notion that work with individuals involves skills of a lesser order than skills of community level participation is debatable. The requisite skills in either area of practice will depend on the professional activity being undertaken. In the current study the clients described skills used by the HV which suggested a considerable degree of expertise. In relation to the delegation of HV activity, Cowley et al. (2000, p 160) observe:

> '*There is an assumption that a number of functions can be delegated that do not need specific health visiting skills, so they can be safely and effectively carried out by the team members mentioned. This is an area where there has been much rhetoric and accusation, but little or no sound research to show whether substitution should be a frequent or occasional feature of health visiting.*'

This is not to criticise community public health approaches, development of the HV role or health visiting teams. However, the legitimacy and the complexity of responding to the needs of individuals needs to be safeguarded in any proposed role development.

Section 12.2 Implications for education

Employing support as a theoretical concept

A seminal textbook for health visiting students notes (Robertson, 1991, p 24):

> '*The key to effective health visiting has always been seen as the development of a good relationship ... informality, that is an open and flexible approach, together with a warm personality, seem important factors.*'

This assertion is reflected in HVs' accounts of their work (Chalmers, 1991; Cowley, 1991; De La Cuesta, 1994) although some of these accounts describe the relationship as a means of achieving *health visiting* aims rather than those of the client (Chalmers, 1991; De La Cuesta, 1994). A later working party investigating outcomes and evaluations in health visiting also observed (Campbell et al., 1995, p 29):

> '*At the core of successful health visiting lies the use of interpersonal and communication skills in establishing a relationship with the client.*'

In a description of this 'therapeutic relationship' the authors suggest that any of the following interventions may be suitable (Campbell et al., 1995, p 29): information giving, emotional support, listening, practical suggestions, referral to another agency. These dimensions of a therapeutic relationship closely resemble the descriptions of support given by the clients in the current study (see Chapter 10.3). Therefore, this study provides empirical evidence to support professional assertions regarding the positive impact of the therapeutic relationship in health visiting. Further, this study suggests that the notion of the relationship in health visiting would be more usefully understood as an aspect of social support. Establishing the link between relationship and support would provide a theoretical underpinning for the health visiting process.

Reviews of different taxonomies of social support (Wortman, 1984; Cutrona and Russell, 1990) identify six different types of support: emotional support which allows the person to feel they are cared for by others; social integration or the sense that an individual is part of a network; bolstering an individual's sense of self-esteem; instrumental aid; offering advice and information; providing information that the individual is part of a network of

reciprocal help (Cutrona and Russell, 1990). All these features of support fit well with health visiting practice. Moreover, clients who described support in the current study identified many of these features (see Chapter 10). The importance of these different elements of support lies in the value they may have in enabling people to avoid or cope with stressful physical or psychological events. Support is not necessarily best given or only given by a professional. There is a recognition of the variety of networks and means by which people or communities may be supported.

Theoretical approaches to social support might also be useful in addressing the following problems noted by Campbell et al. (1995) in judging the effectiveness of a therapeutic relationship:

1. methodological problems may arise with identifying outcomes that may be invisible or defy quantitative analysis
2. outcomes arising from a therapeutic relationship may not be accepted either because they are not associated with health gain and/or perceived to be related to skilled intervention
3. therapeutic interventions may be multidimensional reducing the possibility of tracing outcomes to the specific dimension responsible
4. the outcome of therapeutic interventions may be affected by confounding variables.

With regard to the first point, the current study suggests that clients *are* able to identify inputs and outcomes of social support. Once outcomes have been identified quantitative analysis *may* be used, as demonstrated by a number of established measures for investigating social support (e.g. Bowling, 1994).

Secondly, theoretical and empirical literature reports health gains associated with social support. Goodwin (1991) has also noted the importance of social support in health visiting and suggested the use of relevant literature regarding social support in conveying the value of health visiting to purchasers of services.

The last two methodological issues although problematic are not unique to investigations of health visiting and are also addressed in the social support literature. Investigations of

the effect on individuals of support or the lack of support recognise support is not unidimensional and incorporate measures which measure the concept on several domains (Leavy, 1983). With regard to confounding variables, studies report statistical methods of approaching this problem (e.g. Oakley, 1995).

A further benefit of adopting social support as a theoretical concept for health visiting is that it includes approaches with individuals, *and* groups and communities. This would be particularly useful at a time when the profession is being encouraged to shift its emphasis from working with individuals.

Aspects of communication

The importance of communication skills in HV education has been noted by previous research (Pearson, 1988). Examples provided by previous research indicate the negative outcomes associated with poor communication skills in terms of lack of client participation (Mayall and Foster, 1990; Kendall, 1991). The current study also highlights the importance of communication skills, by providing client's accounts of the contribution of such skills to enabling the client to feel supported. It is *only* through the development of adequate communication skills that support can be offered by the HV.

Whether or not clients recognised support as an element of the visit most identified discussions with HVs. The current study investigated recall of advice/information received by clients as a specific issue regarding communication. It was noted that clients might recall issues but still be dissatisfied and/or reject the advice/information (see Chapters. 6.5, 9.4). Recall of issues might therefore be seen as a necessary but not a sufficient element of client satisfaction and health promotion. Recall has been addressed predominantly in the medical literature, but the current study suggests that educationalists should consider this aspect of communication in the preparation of HVs. This would include such strategies as:

- establishing that the client wanted the advice/information
- ensuring that the client did not already know the advice/information and modifying interventions accordingly

- increasing the likelihood of recall by - discussion of the most important issue first, stressing importance, categorisation of statements, specific advice/information rather than general statements, repetition.

(Ley, 1993)

Analogue studies involving students are reported in the literature investigating recall (for a review of several studies see Ley, 1993). A similar approach requiring health visiting students to recall statements on several issues might help illustrate the potential difficulties faced by clients.

Teaching research methodology

The importance of consumer views in the design and evaluation of care has been increasingly acknowledged (DoH, 1998a). Consumer surveys are one way to evaluate professional standards and will influence funding received by local NHS organisations (DoH, 2000a). This thesis has noted the methodological difficulties involved in previous consumer research regarding health visiting (Chapters 2, 3). Health visitors are required to have knowledge of research methods. However, it might be relevant to focus on methodological approaches which emphasise evaluations of consumer perceptions so practitioners are better prepared to incorporate these approaches in their role. Approaches which combine consumer perceptions of need with community development such as participatory rural appraisal (Chambers, 1994) would be of particular relevance in the development of a community level focus within health visiting.

Section 12.3 Implications for management

Reducing clients' dissatisfaction

Clients in both the clinic and the home visit studies reported two main reasons for reporting helpfulness or importance of the most important topic discussed in neutral or negative terms. Poor quality of information was mentioned by some clients, but the most frequent explanation of neutral or negative ratings was introduction of issues by HVs *without* establishing that clients required the information (see Chapters 6.7.1, 9.2.1). Moreover, even if the advice/information was welcomed, the current study suggest that clients have difficulties *recalling* HVs' advice /information (see Chapters 5.5, 8.5).

A lack of participation between clients and HVs and a didactic, authoritarian approach by HVs have been suggested as contributing to clients' receiving unwanted advice/information (Foster and Mayall, 1990; Kendall, 1991). The current study did not investigate how HVs gave advice/information about particular issues. Therefore, the current study cannot comment whether HVs *were* demonstrating a non-participative or didactic approach. However, there may be other influences on HVs behaviour which increase the likelihood of offering unwanted advice/information. Consideration should be given to the possible constraints placed on HVs to offer advice/information by initiatives at the national policy and local practice level.

Strategic documents concerned with improving health opportunities for families argue carers may require professional input in terms of support, development of parenting skills and advice on a large number of issues (DoH, 1998b; 1998c; 1999a). Specific guidelines for health visiting may be found in reviews of the evidence for child health and work with families (e.g. Hall, 1996; Elkan et al., 2000).

The strategic perspective, underpinned by current evidence, is further shaped by local professional standards and protocols which describe interventions required by the HV in specific areas of her work (e.g. issues to be discussed at a primary visit). Professional standards may be useful for a Trust in developing uniform approaches among practitioners and maintaining consistent service quality. Such management issues will be of particular concern due to the requirements of clinical governance (DoH, 1998a). Local professional standards used by HVs in the current study incorporated a range of issues to be discussed on specific visits in order to optimise the development of children and promote successful parenting. The requirement of standards will vary according to Trusts but the following points may be useful when devising such standards.

Current emphasis is on the need for individuals and communities to have access to health promotion including advice/information on specific issues (DoH, 1998b; DoH, 1999a). It cannot be assumed that encouraging or requiring practitioners to introduce certain topics entails recall or adoption of that advice. A more client-centred approach would be to ensure that primacy was given to *planning* with the client what needs to be discussed, and should be central to any standard. Shared planning could involve documenting what is

perceived by the client as unnecessary to discuss. This would provide a comparison between the perceived needs of the client and those delivering the service. The necessity for a shared approach between client and HV is reinforced by the problem with recall. Improvement in recall is associated with the importance with which advice/information is regarded by the recipient. Establishing that the client is interested in discussing an issue would be an appropriate first step in any health promotion activity.

Recording health visitor activity

The current study reported clients' perspectives regarding outcomes of HVs' work in the CHC and during home visits. This level of detail about health visiting is unusual outside research situations. The current investigation suggests urgent consideration needs to be given to enhancing methods of recording health visiting activity. Health visitors require the opportunity to record the *outcomes* of their work.

Nursing activity in primary care including health visiting has been described as 'largely invisible' (DoH, 1999c). It was noted in a review of HV services in Wales that (Christensen, 2000, p 1):

> '*... there wasn't a Trust in Wales that could demonstrate what health visitors are doing, how they are doing it, for what clients and with what problems.*'

Whilst there may be variation between Trusts, it has been generally observed that traditional systems of recording health visiting activity, which examine number of contacts, may provide little information about quality of a service (Symonds, 1997). It may be difficult to promote or continue with health visiting in the absence of adequate description of its content and outcome. This issue is highlighted by the recent government announcement which accepted the inadcquacy of current approaches to describing health visiting activity and the need to replace it with a better system (Cooper, 2000).

Bond and Thomas (1992, p 52) commented that 'it was up to [nurses] to demonstrate what effects nursing has and what it is that makes nursing effective'. However, attempts to demonstrate effectiveness rely partly on access to relevant systems of recording.

Therefore, it is important that managers can support practitioners in developing improved means of describing the content and impact of their activity.

A possible way forward is the Omaha system (Martin & Scheet, 1992) which records domiciliary health promotion discussions and interventions focused on improving problems. A Likert scale is used to score outcomes at each visit on all issues discussed. Thus, over time a record is available of the impact of the HV's work. The difference between this and existing methods of recording is the focus on outcomes. The current investigation highlights the importance of such an approach, as clients were able to provide details of positive outcomes from the HV's work *not reflected* in current work activity summaries required by the Trust. In addition, development of strategies to identify those elements of the *process* of health visiting interventions which contribute to positive outcomes would be of value in establishing both clinical effectiveness and cost effectiveness.

Section 12.4 Implications for research

Child health clinic

The feasibility and acceptability to clients of introducing a system where they can weigh their own child should be investigated where this is not established practice. Clients could be surveyed regarding their attitude to this to establish its acceptability. Pre-change measures of satisfaction with HV's advice and the CHC service could be compared with similar evaluations after changes had been initiated.

In addition, at a time when changes to the HV's role are being considered, it would be useful to have information on the level of knowledge used by HVs. Responses to vignettes of issues raised by mothers in clinic could be compared between a group of HVs, mothers and potential CHC workers such as nursery nurses and community staff nurses. Such information might illuminate the possible necessity for professional rather than lay knowledge and in the case of the former whether there was an observable difference between workers from professional backgrounds.

Recall

The current study reported clients' decline in recall of advice/information according to the amount received. It was suggested above that educational packages might be developed to improve HVs' abilities to enhance clients' recall. Such interventions would need to be evaluated.

Further information is needed about the client's recall of information regarding the *amount* of advice/information retained on all issues discussed during a visit to the clinic or at home. This is of interest to community nurses other that HVs, particularly practice nurses who are also in the position of giving packages of advice/information.

It would be useful to conduct further studies examining impact of the HV, comparing knowledge levels before and after the HV's visit. One obvious client group would be women with a new baby, whose knowledge base and perception of coping could be measured before and after the HV's first visit.

Developing understanding of support as an outcome in health visiting

This thesis suggests better understanding is required of how provision of support by HVs affects maintenance or enhancement of individuals' well-being. Further studies should examine clients' support networks and the position of the HV within these. Social network and social support network maps would provide understanding of the relative importance or otherwise of the contribution of HVs (Milne, 1999). In addition, they could be used with individuals to gain information on the type of social network development they perceive would be supportive. Such information would also be useful at community intervention level. Social network mapping could be used with focus groups drawn from the HV's caseload. Alternatively, they could be used with specific groups for example: mothers with post natal depression, clients with mental health problems, lone isolated mothers. Mapping can be also be used to examine the contribution or deficits of an individual's personal resources, social life, material resources and home and family life (Hagan and Smail, 1997). Davies (1995) a community midwife, describes mapping family networks as one means of increasing her understanding of mothers and their families on a socially and economically deprived housing estate. These approaches could also provide HVs with additional means to work collaboratively with clients.

In addition to description of the type and form of social networks available to clients, two other aspects of social support need to be understood: information about the function that networks (including HVs) provide, such as emotional help or practical help and the perceived adequacy of the available social support. Future studies should include all three aspects of social support (Milne, 1999). The current study provides a beginning but such descriptions could be developed by in-depth qualitative interviews and the many quantitative measures available (Milne, 1999). It is of particular interest to gain more information about what clients identify as a HV contribution. Future research could compare those who *do* identify support with those who do not, in order to provide information whether certain types of clients or clients in specific situations are likely to benefit particularly from support.

If support is identified as a feature of home visits it is of interest to investigate HVs' perception of this concept. It may be the support reported in the current study did not occur as a deliberate intention of the HV but was an aspect of the HV's intervention that was recognised by certain clients. If clients identify elements of the HV's intervention as beneficial, the service provided by HVs could be improved by increasing their understanding and ability to deliver that intervention.

Allied to such investigation, it would be useful to discover the extent to which HVs currently help clients strengthen their social support networks or improve individual's skills to elicit support. This may be particularly important for clients who need to negotiate with other agencies. This is relevant at a time when the NHS is attempting to challenge social and health inequalities (DoH, 1998c), for example, working with clients who have housing or environmental problems, to identify sources of support, and facilitating a sense of control on the part of the client (empowerment), could arguably be a level of intervention additional to writing a letter of support or offering sympathetic interest.

Section 12.5 Limitations of the study

The current study provides new insights into clients' perceptions of the clinic and of home visits. However, the study is not without shortcomings. These are discussed below.

Representativeness

It is of interest whether the findings of this study can reasonably be extrapolated at a national level to other HVs and their clients. Therefore, consideration has to be given to the representativeness of the study findings.

The study was undertaken in a predominantly urban area. It is impossible to know how far this area resembles or differs from others. However, one notable feature was the lack of an ethnic population within the community. This is of concern in health visiting research as there is a scarcity of investigations which examine the delivery and experience of health visiting among different ethnic groups. However, inclusion of other client characteristics such as employment, relationship, age and number of children enable readers to make comparisons with other areas. Attempts to include other geographic areas and make the study a multi-site project would have been beyond the scope of the study resources.

The number of HVs who participated in the study was small, and as stated earlier, the fact that they were volunteers might suggest they were particularly committed and confident practitioners (see Chapter 4). This raises the problem of how far the work of such HVs can be taken to represent that of their colleagues. Findings in the current study may not be replicated across a broader range of HVs. This does not invalidate the findings within the study but may suggest that they describe a particular approach to practice.

A similar problem is found in the sample of clients interviewed regarding the clinic and home visits. Clients interviewed about the clinic were a convenience sample and this might be considered a source of bias. In hindsight it would have been useful to have collected client characteristics of those who were not invited into the study, those who did but refused, and those who agreed to be interviewed, but were not at home when the researcher visited. Those not seen might have been dissatisfied clients, thus biasing the findings towards positive clients' accounts. However, comparatively few declined to participate or were not at home when the researcher called. Furthermore, clients interviewed *did* include mothers who were dissatisfied.

For the home visits, an attempt was made to ensure a wide selection of clients and reduce the likelihood of the HVs choosing clients. Researcher control over recruitment of clients

was limited and therefore it is not possible to know whether the recruitment of clients was biased. However, characteristics of those not seen and those who refused to participate or were excluded by the HV did not reveal any apparent differences from those who were interviewed. In addition, not all clients interviewed were positive towards their HV which might suggest that if HVs, *were* choosing clients that it was not necessarily possible for them to know who would provide a positive account.

Recall

One of the aims of the study was to investigate clients' recall of advice/information. The study might be criticised for failing to provide sufficient detail in terms of the *level* of recall for *all* issues. To have done so would have involved many more questions regarding information. This would have necessitated removing questions about clients' perceptions and support because of the increase in length. In addition, it would have involved either detailed recording by the HVs or audio taping of their interviews.

The former was not acceptable because of the increased amount of work for the HVs, and the latter might have altered HVs' interaction or stimulated clients' ability to recall items. However, future research might focus on discrete areas of recall and clients' perceptions of support now that the current study has identified areas of research interest.

Section 12.6 Conclusion

Observations made when the thesis proposal was being developed alluded to lack of knowledge about health visiting activity (Audit Commission, 1994). Remarks were made to the effect that HVs should be returned to uniform and deliver clinical care along the lines of traditional nursing interventions (Roberts., 1996a). In a time of limited resources and increasing demand for NHS services it is understandable that there should be concern to ensure that only valid roles are undertaken. The problem is *what* activity is to count as valid. Questions regarding lack of knowledge about health visiting activity and debate about future directions of such activity are still current (DoH, 1999c; Cowley et al., 2000).

Previous descriptions of the work of HVs in the CHC provided ambiguous descriptions regarding the relevance of their input (see Chapter 3.4). The current study described outcomes for clients of a discussion with the HV in the CHC and during home visits. In

the clinic, these accounts identified the contribution that can be made by the HV but also indicated the importance of shaping services to the client's needs (see Chapter 7). This investigation therefore provides some balance to previous research which focused on outcomes of medical or developmental services in the CHC (see Chapter 3.2). This medical focus, whilst legitimate when concerned with investigations within its own sphere, risks obscuring client defined needs and work by other staff. As a consequence, clients' defined needs and non-medical interventions may become invisible.

Clients' perspectives of a home visit provide clarification of outcomes of the advisory work of HVs in this setting (see Chapter 11). This builds on previous consumer surveys which focused on content rather than outcomes of home visits. The current study also provides, for the first time, empirical evidence of the impact of support provided by the HV during the home visit (see Chapter 10). However, as with the clinic study, questions are also raised regarding the degree to which HVs are encouraged and/or inclined to adopt a client centred approach.

The current study reports, through consumer perspectives, the work of the HV. Consumers provided positive information about this work but also highlighted tensions between client and professional agendas. Increased understanding about the needs of the former and the work of the latter are integrally entwined in any future service development that is going to be relevant to consumers' needs. The validity of a service does not rest solely on professional stakeholders, but is also dependent on the views of service users.

Based on consumer perspectives, the current study offers tentative evidence of the usefulness and acceptability of health visiting interventions. Firstly, in CHCs most clients were *seeking* advice/information from the HV, expressed satisfaction and utilised the advice/information. The majority of clients perceived discussion with HVs as important and helpful. Secondly, the majority of accounts of home visits described clients either receiving new advice/information or seeking advice/information from the HV in order to resolve or manage a problem or anxiety. Most regarded this discussion as important and helpful. In addition, over half the clients referred to receiving support from the HV. These findings arguably suggest it is possible to investigate HV activities and that these activities are perceived as valid by the consumer.

At the time of completion of this thesis, the notion of prevention and the importance of support to individuals and communities has acquired legitimacy at least at the level of strategic documents (DoH, 1998b; DoH, 1999a). This legitimacy is provided by the available existing knowledge regarding the effect of lifestyles and inequalities on the health and social outcomes for individuals and communities (DoH 1998c; 1999a). The challenge for HVs is to investigate *their* contribution to positive outcomes in these areas of concern.

Section 12.7 Summary of recommendations

Recommendations for practice

- The organisation of CHCs should reflect clients' needs in particular communities.
- The primary purpose for HVs in their *advisory* roles within CHCs should be to respond to clients' enquiries and use the CHCs for a secondary professional agenda.
- Collaboration between HV and client regarding any discussions is essential in order to reduce dissatisfaction with the service.

Recommendations for education

- Advice/information giving is part of the HV role. Practitioners should be made aware of strategies to help them be more effective in communicating such advice/information.
- Practitioners require an understanding of support in terms of the taxonomies, necessary skills and the positive outcomes that may accrue for individuals or groups.
- Practitioners need an understanding of the problems with eliciting consumer perspectives, the different approaches that might be used and how they can best use these in community development work, commissioning or providing information about HV services.

Recommendations for management

- Without *individual* assessment, guidelines/standards risk becoming prescriptive and didactic. Health visitors should be encouraged to employ a partnership approach with clients when assessing their need or desire for advice/information.
- Health visiting activity will remain largely invisible without detailed attempts to describe it. Data recording systems of HV activity should attempt to describe the wide variety of work and the associated outcomes.

Recommendations for research

Future work should focus on the:

- Development of research which investigates the health visiting service provided to different ethnic populations should be developed.
- Evaluation of CHCs where the clients are allowed to weigh their own children.
- Evaluation of educational packages to enable HVs to increase client's recall of advice/information received.
- Investigation of the relationship between the concept of support and health visiting activity.
- Investigation of the understanding and meaning of support among HVs.
- Examination of the value of network/social support mapping between HVs and their clients.
- Investigation of the contribution of HV in cases where clients receive input from several agencies.
- Further identification of processes and outcomes in health visiting.

REFERENCES

Acheson, R. (1962) Attitudes of mothers to infant and child health and welfare clinics. *British Medical Journal*, 1355-1359.

Anderson, J. (1979) Patients' recall of information and its relation to the nature of the consultation. *In* Oborne,D. J, Gruneberg, M.M Eiser, J,R. (Eds). *Research in Psychology and Medicine, Volume 2.* London. Academic Press.

Audit Commission (1994) *Seen But Not Heard: Coordinating Community Child Health and Social Services for Children in Need.* London: HMSO.

Banyard, P and Hayes, N. (1994) *Psychology Theory and Application.* London: Chapman and Hall.

Barker, W. and Percy, P. (1991) Health visiting under scrutiny. *Health Visitor* 64; 1: 12-15.

Barnes, M. (1992) Clinics for healthy children. *The Practitioner* 286: 908-911.

Barribal, L. and Mackenzie, A. (1994) Measuring the impact of nursing interventions in the community: a selective review of the literature. *Journal of Advanced Nursing* 18: 401-407.

Bax, M., Hart, H. and Jenkins, S. (1980) *The Health Needs of the Pre-school Child.* London: Thomas Coram Research Unit.

Bertakis, K. (1977) The communication of information from physician to patient: a method for increasing patient retention and satisfaction. *The Journal of Family Practice* 5; 2: 217- 222.

Billingham, K. (1991) New ways of working. *Health Visitor* 64; 2: 40-43.

Biswas, B. and Sands, C. (1984) Mothers' reasons for attending a child health clinic. *Health Visitor* 57; 2: 41-42.

Blaxter, M. and Paterson, E. (1982) *Mothers and Daughters: A Three-Generational Study of Health Attitudes and Behaviour.* London: Heinemann Educational Books.

Bloom, J. (1990) The relationship of social support and health. *Social Science Medicine* 30; 5: 635-637.

Bolton, P. (1984) A survey of child health clinics in Thanet Kent. *Health Visitor* 57: 42-43.

Bond, S. and Thomas, L. (1992) Input on outcomes. *Nursing Times* 88; 38: 50-52.

Bonell, C. (1999) Evidence-based nursing: a stereotyped view of quantitative and experimental research could work against professional autonomy and authority. *Journal of Advanced Nursing* 30; 1: 18-23.

Boulton, D. and Hammersley, M. (1996) Analysis of unstructured data. *In* Sapsford, R and Abbott, J. (1996) (Eds) *Data Collection and Analysis*. London. Sage publications.

Bowers, D. (1996) *Statistics from Scratch an Introduction for Health Care Professionals.* Chicheste: John Wiley and Sons.

Bowling, A. (1994) *Measuring Health a Review of Quality of Life Measures.* Buckingham: Open University Press.

Broadhead, E., Kaplan, B., James, S., Wagner, E., Schoenbach, V., Grimson, R., Heyden, S., Tibblin, G. and Gehlbach, S. (1983) The epidemiologic evidence for a relationship between social support and health. *American Journal of Epidemiology* 117; 5: 521-537.

Brown, G. and Harris, T. (1978) *Social Origins of Depression: A Study of Psychiatric Disorder in Women*. Cambridge: Tavistock publications.

Bryman, A. (1984) The debate about quantitative and qualitative research: a question of method or epistemology? *The British Journal of Sociology* XXXV; 1: 75-92.

Bryman, A. (1988) *Quantity and Quality in Social Research*. London: Unwin Hyman.

Bryman, A. and Cramer, D. (1990) *Quantitative Data Analysis for Social Scientists*. Kent: Routledge.

Burnard, P. (1991) A method of analysis interview transcripts in qualitative research. *Nurse Education Today* 11: 461-466.

Burnard, P. (1994) Analysing data using a word processor. *Nurse Researcher* 1; 3: 33- 42.

Burnard, P. (1995) Teaching the analysis of textual data: an experiential approach. *Nurse Education Today* 16: 278-281.

Burnard, P. (1998) *Qualitative Data Analysis*. Centre for Community Nursing Seminar. University of Hull. June 1998. (Unpublished seminar paper).

Burns, N. and Grove, S. (1993) *The Practice of Nursing Research: Conduct, Critique and Utilisation*. (2nd Edition). London. W.B. Saunders Company.

Calnan, M. (1988) Towards a conceptual framework of lay evaluation of health care. *Social Science Medicine* 27; 9: 927-933.

Cameron , S. (1994) *First Time Mothers and Their Health Visitors: Perceptions of a Home Visit.* Unpublished PhD Thesis. Edinburgh University.

Campbell, F., Cowley, S, and Buttigieg, M. (1995). *Weights and Measures.* London: Health Visitors Association.

Caplan, G. (1974) *Support Systems and Community Mental Health.* New York: Behavioural Publications.

Carney, O., McIntosh, J., Worth, A. and Lugton, J. (1996) *Assessment of Need for Health Visiting.* Department of Nursing and Community Health. Glasgow Caledonian University.

Cassel, J. (1974) The contribution of the social environment to host resistance. *American Journal of Epidemiology* 104; 2: 107- 123.

Cavanagh, S. (1997) Content analysis: concepts, methods and applications. *Nurse Researcher* 4; 3: 5-15.

Chalmers, K. (1990) *Preventive Work with Families in the Community: A Qualitative Study of Health Visiting Practice.* Unpublished PhD thesis. Manchester University.

Chalmers, K. (1992) Giving and receiving; an empirically derived theory on health visiting practice. *Journal of Advanced Nursing* 17: 1317-1325.

Chalmers, K. (1993) Searching for health needs: the work of health visiting. *Journal of Advanced Nursing* 18: 900-911.

Chalmers, K. and Luker, K. (1991) The development of the health visitor-client relationship. *Scandinavian Journal of Caring Science* 5; 1: 33-41.

Chambers, R. (1994) Participatory Rural Appraisal (PRA): Analysis of experience. *World Development* 22; 9: 1253-1268.

Christensen, J. (2000) Omaha Master Class Pack - 26 June. University of Wales. Swansea School of Health Science.

Clark, J. (1973) *A Family Visitor: A Descriptive Analysis of Health Visiting in Berkshire.* London: Royal College of Nursing.

Clark, J. (1981) *What Do Health Visitors Do? Review of the Research 1960-1980.* London: Royal College of Nursing.

Clark, J. (1984) Mothers' perceptions of health visiting. *Health Visitor* 57: 265-268.

Clark, J. (1985) *The Process of Health Visiting.* Unpublished PhD Thesis. South Bank Polytechnic.

Closs, J. and Cheater F. (1999) Evidence for nursing practice - a clarification of the issues. *Journal of Advanced Nursing* 30; 1: 10-17.

Cobb, S. (1976) Social support as a moderator of stress. *Psychometric Medicine* 38; 5: 300-314.

Cohen, S. (1992) Stress, social support, and disorder. *In* Veiel, H and Baumann, U. (Eds) *The Meaning and Measurement of Social Support.* New York: Hemisphere Publishing Corporation.

Cohen, S. and Wills, H. (1985) Stress, social support, and the buffering hypothesis. *Psychological Bulletin* 98; 2: 310-357.

Cole, F. (1988) Content analysis: process and application. *Clinical Nurse Specialist* 2; 1: 53- 57.

Colliety , P. (1989) An evaluation of the health visiting process. *Senior Nurse* 9; 1: 13-16.

Committee on Child Health Services (1976) *Fit for the Future: Report on the Committee on Child Health Service.* London: HMSO.

Community Development Interest Group (1998) *Community Development - Future Opportunities in Health.* London: Community Practitioners and Health Visitors' Association.

Community Practitioners and Health Visitors Association (2000) *Leading the Future.* London: Community Practitioners and Health Visitors Association.

Cooper, Y. (2000) Opening address given by Parliamentary Under Secretary of State for Public Health at the Community Practitioners' and Health Visitors' Annual Professional Conference. Harrogate.

Council for the Education and Training of Health Visitors (1977) *An Investigation into the Principles of Health Visiting.* London: Council for the Education and Training of Health Visitors.

Cowley, S. (1991) A symbolic awareness context identified through a grounded theory of health visiting. *Journal of Advanced Nursing* 16: 648-656.

Cowley, S. (1991) *A Grounded Theory of Situation and Process in Health Visiting.* Unpublished PhD Thesis. Brighton Polytechnic.

Cowley, S. (1995) Health-as-process: a health visiting perspective. *Journal of Advanced Nursing* 22, 433-441.

Cowley, S., Buttigieg, M. and Houston, A. (2000) *A First Steps Project To Scope the Current and Future Regulatory Issues for Health Visiting.* London. United Kingdom Central Council for Nursing Midwifery and Health Visiting. (Unpublished report).

Cowman, S. (1993) Triangulation: a means of reconciliation in nursing research. *Journal of Advanced Nursing* 18: 788-792.

Cowpe, M., MacLachlan. A. and Baxter, E. (1994) Clients' views of a health visiting service. *Health Visitor* 67; 11: 390-391.

Craig, P. (1995) *A Different Role: Health Visiting in a Community Project.* Glasgow Healthy City Project.

Craig , P. (1998) Health visiting and public health: back to our roots or a new branch? *Health and Social Care in Community* 6; 3: 172-180.

Cubon, J. (1987) Consumer Attitudes to Child Health Clinics. *Health Visitor* 60: 85-186.

Cutrona, C. and Russell, D. (1990) Type of social support and specific stress: toward a theory of optimal matching. *In* Sarason, B., Sarason, I. and Pierce, G. (Eds) *Social Support: An Interactional View.* New York: John Wiley and Sons.

Dalziel, Y. (1992) Breaking down the barriers. *Health Visitors* 65; 7: 228-229.

Davies, J. (1995) A study of family networks and relationships in community midwifery. *In* Reed, J. and Procter, S. *Practitioner Research in Health Care.* London: Chapman and Hall.

De La Cuesta, C. (1992) *Marketing the Service: Basic Social Process in Health Visiting.* Unpublished PhD thesis. Liverpool University.

De La Cuesta, C. (1994) Marketing: a process in health visiting. *Journal of Advanced Nursing* 19: 347-353.

Denzin, N. (1970) Strategies of multiple triangulation. *In* Denzin, N. (Ed) *The Research Act.* New York: McGraw Hill.

Department of Health (1989) *Child Health Surveillance in Primary Care a Critical Review.* London: HMSO.

Department of Health (1996) *Child Health in the Community: A Guide to Good Practice.* Department of Health.

Department of Health (1997) *The New NHS, Modern, Dependable.* London: The Stationary Office.

Department of Health (1998a) *A First Class Service.* London: The Stationary Office.

Department of Health (1998b) *Supporting Families.* London: The Stationary Office.

Department of Health (1998c) *Report of the Independent Inquiry into Inequalities in Health.* London: The Stationery Office.

Department of Health (1999a) *Saving Lives: Our Healthier Nation.* London: The Stationary Office.

Department of Health (1999b) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare.* London: The Stationary Office.

Department of Health (1999c) *NHS R&D Strategic Review: Primary Care Annex.* London: The Stationary Office.

Department of Health (2000a) *The NHS Plan.* London: The Stationary Office.

Department of Health (2000b) *Towards a Strategy for Nursing Research and Development.* Department of Health.

Dingwall, R. (1997) Collectivism, regionalism and feminism: health visiting and British social policy 1850-1975. *Journal of Social Policy* 6; 3: 291-315.

Donabedian, A. (1992) Quality assurance in health care: consumers role. *Quality in Health Care* 1: 247-251.

Douglas, J. and Blomfield, J. (1958) *Children Under Five.* London: George Allen and Unwin.

Dworkin, P., Dworkin, S., Bernstein, B., Sefi, S. and Macfarlane, A. (1990) Maternal perceptions of child health care. *Health Visitor* 63; 10: 339-341.

Elkan, R., Kendrick, D., Hewitt, Robinson, J., Tolley, K., Blair, M., Dewey, M., Williams D., and Brummell K. (2000) *The Effectiveness of Domiciliary Visiting: A Systematic Review of International Studies and a Selective Review of the British literature.* Basingstoke Press: Core Research, Alton.

Fagan, J. (1997) Non-attenders for child health surveillance: life chance factors. *Health Visitor* 70; 3: 103-104.

Field S., Draper, J., Kerr, M. and Hare, M. (1982) A consumer view of the health visiting service. *Health Visitor* 55; 6: 299-301.

Field, P. and Morse, J. (1990) *Nursing Research: The Application of Qualitative Approaches.* (2nd Edition), London: Chapman and Hall.

Fink, A. (1995) *How to Design Surveys Volume 1.* Thousand Oaks California: Sage Publications.

Foddy, W. (1996) *Constructing Questions for Interviews and Questionnaires.* Hong Kong: Cambridge University Press.

Forester, S. (1982) Don't sit on the political fence. *Nursing Mirror* 3, November: 28-29.

Foster, M. and Mayall, B. (1990) Health visitors as educators. *Journal of Advanced Nursing* 15: 286-292.

Foster, M. and Mayall B. (1990) Health visitors as educators. *Journal of Advanced Nursing* 15: 286-292.

Foster, P. (1996) Observational research. *In* Sapsford, R. and Abbott, J. (1996) (Eds) *Data Collection and Analysis*. London: Sage publications.

Foxman, R., Moss, P., Bolland, G. and Owen, C. (1982) A consumer view of the health visitor at six weeks postpartum. *Health Visitor* 55; 6: 302-308.

Frank, J. (1983) The placebo is psychotherapy. *The Behavioural and Brain Sciences* 2: 291.

Gantley, M. (1994) The qualitative and the quantitative: an anthropological perspective on research methods. *Critical Public Health* 5; 3: 27-32.

Garnett, L., Niggebrugge, A., Everett, G. and Douglas, M. (2000) *A Social Atlas of Community Care Needs*: *Care Needs Assessment Project Community*. Hull. East Riding Health Authority/Kingston Upon Hill City Council.

Gastrell, P. (1986) Child health centres - parental and professional views. *In* While, A. (Ed) *Research in Preventive Community Nursing Care*. London: John Wiley and Sons Ltd.

Gibbon, B. (1995) Validity and reliability of assessment tools. *Nurse Researcher* 2; 4: 48-55.

Glaser, B. (1978) *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. California: Sociology Press Mill Valley.

Goodwin, S. (1991) Community nursing and the new public health. *Health Visitor* 65; 3: 78-80.

Gottlieb, B. (1985) Social networks and social support: An overview of research, practice, and policy implications. *Health Education* 12; 1: 5-22.

Gottlieb, B. (1987) Using social support to protect health. *Journal of Primary Prevention* 8; (1&2), Fall/Winter: 49-70.

Graham, H. (1979) Women's attitudes to the child health services. *Health Visitor* 52: 175-178.

Greene, J. and D'Oliveira, M. (1982) *Learning to Use Statistical Tests in Psychology: A Student's Guide.* Milton Keynes: Open University.

Hagan, T. and Smail, D. (1997) Power mapping - 1. Background and basic methodology. *Journal of Community and Applied Social Psychology* 7: 257-267.

Hall, D. (Ed) (1989) Health for all children. Oxford: Oxford University Press.

Hall, D. (Ed) (1991) Health for all children. (2nd Edition) Oxford: Oxford University Press.

Hall, D. (Ed) (1996) Health for all children.(3rd Edition) Oxford: Oxford University Press.

Hammersley, M. (1992) *What's Wrong with Ethnography?* (2nd Edition) London: Routledge.

Hammersley, M and Atkinson, P. (1997) *Ethnography Principles and Practice.* London: Routledge.

Hardey, M. (1994) Qualitative research and nursing. *In* Hardey, M. and Mulhall, A. (Eds) *Nursing Research Theory and Practice.* London: Chapman and Hall.

Hart, H., Bax, M. and Jenkins S. (1981) Use of the child health clinic. *Archives of Disease in Childhood* 56: 440-445.

Hasse, J. and Myers, S. (1988) Reconciling paradigm assumptions of qualitative and quantitative research. *Western Journal of Nursing Research* 10; 2: 128-137.

Hendrickse, W. (1982) How effective are our child health clinics? *British Medical Journal* 284: 575-577.

Heritage, J. and Sefi, S. (1997) Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. *In* Drew, P. and Heritage, J. *Talk at Work: Interaction in Institutional Settings.* Cambridge University Press.

Holcomb. L. and Moore, M. (1993) Personal meaning of death: a content analysis of free-response narrative. *Death Studies* 17: 299-318.

Holloway, I. and Wheeler, S. (1996) *Qualitative Research for Nurses.* Oxford: Blackwell Science.

Holsti, O. (1969) *Content Analysis for the Social Sciences and the Humanities.* Massachusetts: Addison-Wesley.

House, J. and Khan, R. (1985) Measures and concepts of social support. *In* Cohen, S, and Syme, L. (Eds) *Social Support and Health.* Orlando: Academic Press Inc. (London) Ltd.

Illingworth, R. (1979) Some experience in an area health authority child health clinic. *British Medical Journal* 1: 866-869.

Jestice, S. and Watkins, J. (1995) *Health Visitor Survey: Helping Us Improve the Health Visiting Service.* Cambridge: Lifespan Health Care.

Jick, T. (1979) Mixing qualitative and quantitative methods: triangulation in action. *Administrative Science Quarterly* 24: 602-611.

Joyce, C., Caple, G., Mason, M., Reynolds, E. and Mathews, J. (1969) Quantitative study of doctor-patient communication. *Quarterly Journal of Medicine*, New series XXXV111: 150.

Karmali, J. and Madely, R. (1985) Mothers' attitudes to a child health clinic in a deprived area of Nottingham. *Public Health* 100: 156-165.

Kendall, S. (1991) *An Analysis of the Health Visiting-Client Interaction: The Influence of the Health Visiting Process on Client Participation.* Unpublished PhD Thesis. King's College University, London.

Knott, M and Latter, S. (1999) Help or hindrance? Single, unsupported mothers' perceptions of health visiting. *Journal of Advanced Nursing* 30; 3: 580-588.

Lazarus, R. and Folkman, S. (1984) *Stress, Appraisal and Coping.* New York: Springer Publishing Company.

Leavy, R. (1983) Social support and psychological disorder: a review. *Journal of Community Psychology* 11: 3-21.

Leggett, P. (1985) Study of child health clinic. *Health Visitor* 58; 5: 130-131.

Leininger, M. (1992) Current issues, problems, and trends to advance qualitative paradigmatic research methods for the future. *Qualitative Health Research* 2; 4: 392-415.

Ley, P. (1973b) Communication in the clinical setting. *British Journal of Orthodontics* 1; 4: 173-177.

Ley, P. (1979) Improving clinical communication: effects of altering doctor-behaviour. *In* Oborne, D., Gruneberg, M. and Eiser, J. *Research in Psychology and Medicine Volume 11.* London: Academic Press.

Ley, P. (1993) *Communicating with Patients Improving Communication, Satisfaction and Compliance.* London: Chapman and Hall.

Ley, P., Bradshaw, W., Eaves, D. and Walker, C. (1973a) A method for increasing patients' recall of information presented by doctors. *Psychological Medicine* 3: 217-220.

Ley, P., Whitworth, M., Skilbeck, C., Woodward, R., Pinsent, R., Pike, L., Clarkson, M. and Clark, P. (1976) Improving doctor-patient communication in general practice. *Journal of the Royal College of General Practitioners* 26: 720-724.

Lightfoot, J. (1994) Demonstrating the value of health visiting. *Health Visitor* 67; 1: 19-20.

Loveland, M. (1968) The health visitor in the health centres. *In* Hale, R., Loveland, M. and Owen, G. *The Principles and Practice of Health Visiting.* Oxford: Pergamon Press.

Lowe, R. (1988) Reform or die. *Nursing Times* 84; 42: 74.

Luker, K. (1980) *Health Visiting and the Elderly: An Experimental Study to Evaluate the Effects of Focused Health Visitor Intervention on Elderly Women Living Alone.* Unpublished PhD Thesis. University of Edinburgh.

Luker, K. and Chalmers, K. (1990) Gaining access to clients: the case of health visiting. *Journal of Advanced Nursing* 15: 74-82.

Machen, I. (1993) *The Relevance of Health Visiting Policy to Mothers - A Historical and Contemporary Analysis.* Unpublished MA thesis. University of Hertfordshire.

Madge, N. and Marmot, M. (1987) Psychosocial factors and health. *Quarterly Journal of Social Affairs* 3; 2: 81-134.

Marris, T. (1971) *Research Report No 12 The Work of the Health Visitors in London.* London: Greater London Council Department of Planning and Transportation.

Martin, K. and Scheet, N. (1992) *The Omaha System a Pocket Guide for Community Health Nursing.* Philadelphia: W.B. Saunders Company.

McCleary, G. (1933) *Early History of the Infant Welfare Movement.* London: H.K. Lewis and Co.Ltd.

McCleary, G. (1935) *Maternity and Child Welfare Movement.* London: P.S. King and Son Ltd.

McIntosh, J. (1986) *A Consumer Perspective on the Health Visiting Service.* University of Glasgow: Social Paediatric and Obstetric Research Unit.

McIntosh, J. (1992) The perception and use of child health clinics in a sample of working class families. *Child: Care, Health and Development* 18: 133-150.

Merkouris, A., Ifantopoulos, J., Lanara, V. and Lemonidou, C. (1999) Patient satisfaction: a key concept for evaluation and improving nursing services. *Journal of Nursing Management* 7: 19-28.

Miller, F. (1960) *Growing up in Newcastle Upon Tyne.* London: Oxford University Press.

Milne, D. (1999) *Social Support a Guide to Social Support Interventions for Mental Health Practitioners.* Chichester: John Wiley and Sons.

Ministry of Health (1967) *Central Health Service Council: Report of Subcommittee on Child Welfare Centres.* London: HMSO.

Mitchell, E. (1986) Multiple triangulation: a methodology for nursing science. *Advances in Nursing Science* 8; 3: 18-26.

Montgomery-Robinson, K. (1987) *The Social Construction of Health Visiting.* Unpublished PhD Thesis, The Polytechnic of the South Bank.

Morgan, M., Reynolds, A., Morris, R., Allsop, M. and Rona, R. (1989) Who uses child health clinics and why: a study of a deprived inner city district. *Health Visitor* 62: 244-247.

Moser, C. and Kalton G. (1971) *Survey Methods in Social Investigation.* Hampshire: Gower.

Moss, P., Bolland, G., Foxman, R. and Owen, C. (1986) The first six months after birth: mothers' views of health visitors. *Health Visitor* 59: 71-74.

Munro, B. and Page E. (1993) *Statistical Methods for Health Care Research.* (2nd Edition) Philadelphia: J.B. Lippincott Company.

Newsholme, A. (1935) *Fifty Years in Public Health.* London: Allen and Unwin.

Nicoll, A. (1983) Community child health services - for better or worse? *Health visitor* 56: 241- 243.

Oakley, A. (1988) Is social support good for the health of mothers and babies? *Journal of Reproductive and Infant Psychology* 6: 3-21

Oakley, A. (1992) *Social Support and Motherhood the Natural History of a Research Project.* Oxford: Blackwell.

Oakley, A., Hickey, D., Rajan, L. and Rigby, A. (1996) Social support in pregnancy: does it have long-term effects? *Journal of Reproductive and Infant Psychology* 14: 7-22.

Oakley, A., Rajan, L. and Grant, G. (1990) Social support and pregnancy outcome: report of a randomised controlled trial. *British Journal of Obstetrics and Gynaecology* 8: 45-55.

Office for National Statistics (1998) *Living in Britain: Results from the General Household Survey*. London: The Stationery Office.

Orr, J. (1980) *Health Visiting in Focus. A Consumer View of Health Visiting in Northern Ireland*. London: Royal College of Nursing.

Patton, M. (1990) *Qualitative Evaluation and Research Methods*. (2nd Edition) London: Sage publications.

Pearson, P. (1984) Images of a health visitor. *Nursing Mirror* 159; 19: 21-23.

Pearson, P. (1988) *Client's Perceptions of Health Visiting in the Context of their Identified Health Needs: an Examination of Process*. Unpublished PhD thesis. Newcastle - upon-Tyne Polytechnic.

Pearson, P. (1991) Clients perceptions: the use of case studies in developing theory. *Journal of Advanced Nursing* 16: 521-528.

Polit. D. and Hungler, B. (1999) *Nursing Research Principles and Methods*. (6th edition). Philadelphia: Lippincott.

Pratt, V. (1978) *The Philosophy of the Social Sciences*. Cambridge: Universtity Press,

Quine, L. and Povey, R. (1993) *A Study of Client Satisfaction with the Health Visitor Service*. Centre for Research in Health Behaviour Institute of Social and Applied Psychology. University of Kent/South Kent Community Health Care.

Roberts, C. (1996a) An untestable assertion? *Health Services Journal*, 7 March: 32-33.

Roberts, C. (1996b) The proof of the pudding. *Health Services Journal*, 14 March: 27

Robertson, C. (1991) *Health Visiting in Practice.* (2nd Edition). Churchill Livingstone: London.

Robinson, J. (1982) *An Evaluation of Health Visiting.* London: Council for the Education and Training of Health Visitors

Sackett, D. and Wennberg, J. (1997) Choosing the best research design for each question. *British Medical Journal* 315; 20-27 December: 1096.

Sandelowski, M. (1995) Triangles and crystals: on the geometry of qualitative research. *Research in Nursing and Health* 18: 569-574.

Sapsford, R. and Abbott, J. (1996) Ethics, politics and research. *In* Sapsford, R and Abbott, J. (Eds) *Data Collection and Analysis.* London: Sage publications.

Sapsford, R. and Jupp, J. (1996) Validating Evidence. *In* Sapsford, R. and Abbott, J. (Eds) *Data Collection and Analysis.* London: Sage publications.

Sapsford, R. (1999) *Survey Research.* London: Sage publications.

Sarafino, E. (1990) *Health Psychology Biopsychosocial Interactions.* New York: John Wiley and Sons.

Sefi, S. (1988) Health visitors talking to mothers. *Health Visitor* 61; 1: 7-10.

Sefi, S. and Grice, D. (1994) Parents' views of clinics. *Health Visitor* 67; 2: 62.

Sefi, S. and Macfarlane, A. (1985) Child health clinics: why mothers attend. *Health Visitor* 58; 5: 129-130.

Sefi, S. and Macfarlane, A. (1987) Increasing health visitor involvement in child health surveillance. *Health Visitor* 60: 223-224.

Seers, K. (1994) Qualitative and Quantitative Research. *Surgical Nurse* 7; 6: 4-6.

Sharpe, H and Lowenthal, D. (1992) Reasons for attending GP or health authority clinics. *Health Visitor* 65; 10: 349-351.

Sherrat, F., Johnson, A. and Holmes, S. (1991) Responding to parental concerns at the six month stage. *Health Visitor* 64; 3: 84-86.

Silver, R., Wortman, C. and Crofton, C. (1990) The role of coping in support provision: the self presentational dilemma of victims of life crises. *In* Sarason, B., Sarason, I. and Pierce, G. (Eds) *Social support: An Interactional View.* New York: John Wiley and Sons.

Smeaton, R. (2000) *University of Hull Library Information Sheet.* University of Hull.

Speedling, E. and Rose D. (1985) Building an effective doctor-patient relationship: from patient satisfaction to patient participation. *Social Science Medicine* 21; 2: 115-120.

Spence J., Walton, W., Miller, F. and Court S. (1954) *A Thousand Families in Newcastle upon Tyne, an Approach to the Study of Health and Illness in Children.* London: The Nuffield Foundation and the Nuffield Provincial Hospital Trust/Oxford University Press.

Stansfeld, S. (2000) Social support and social cohesion. *In* Marmot, M. and Wilkinson, G. (Eds) *Social Determinants of Health.* Oxford University Press.

Steiner , H. (1977) An evaluation of child health clinic services in Newcastle upon Tyne during 1972-1974. *British Journal of Preventive and Social Medicine* 31: 1-5.

Stewart, M. (1993) *Integrating Social Support in Nursing.* London: Sage publications.

Symonds, A. (1993) Health visiting and the new public health. *Health Visitor* 66; 6: 204-206.

Symonds, A. (1997) Medical mantras: why health visiting risks losing its way. *Health Visitor* 70; 3: 99-100.

Thoits, P. (1986) Social support as coping assistance. *Journal of Consulting and Clinical Psychology* 54; 4: 416-423.

Too, S. (1996) Issues in qualitative research: practical experiences in the field. *Nurse Researcher* 3; 3: 80-91.

Traynor, M. (1993) Some current issues for health visiting. *Health Visitor* 66; 6: 216-218.

Twinn, S. (1991) Conflicting paradigms of health visiting: a continuing debate for professional practice. *Journal of Advanced Nursing* 16: 966-973.

Veiel, H. and Baumann, U. (1992) The many meanings of social support. *In* Veiel, H. and Baumann, U. (Eds) *The Meaning and Measurement of Social Support.* USA: Hemisphere Publishing Corporation.

Warner U. (1983) *The Social Organisation of Health Visiting.* Unpublished MSc thesis. Surrey University.

Watson, E. (1986) A mismatch of goals. *Health Visitor* 59: 75-78.

Watson, P. (1981) *A Time Study of Health Visitors' Work.* Unpublished PhD thesis.University of Aberdeen.

Watson, E. and Sim, J. (1989) The health visitor's visit. *Health Visitor* 62: 214-217.

Weatherley, D. (1988) A survey of clients' views in one health visitor's caseload. *Health Visitor* 61; 5: 137-138.

Webb, C. (1999) Analysing qualitative data: computerised and other approaches. *Journal of Advanced Nursing* 29; 2: 223-330.

While, A. (1985) *Health Visiting and Health Experience of Infants in Three Areas*. K ings College University, London.

While, A. (1986) The uptake of prophylactic care during infancy. *In* While, A. (Ed) *Research in Preventive Community Nursing Practice*. Chichester: John Wiley.

While, A. (1989) Health visiting practice and young children. *In* Wilson-Barnett, J. and Robinson, S. (Eds) *Directions in Nursing Research: Ten Years of Progress at London University*. London: Scutari Press.

Williams, P. (1991) The value of child health clinics. *Update* 15 January: 137- 140.

Williams, S. (1992) Seizing the public health initiative. *Health Visitor* 64; 2: 48-50.

Williams, P. and Argent, E. (1981) A study of an urban health centre: factors influencing contact with mothers and babies. *Child Care: Health and Development* 7: 255-266.

Willis, J. (1997) Health visiting: which way forward? *Nursing Times* 93; 43: 56-57.

Wilson, M. (1996) Asking questions. *In* Sapsford, R. and Abbott, J. (Eds) *Data Collection and Analysis*. London: Sage publications.

Wincfield, H. (1987) Psychotherapy and social support: parallels and differences in the helping process. *Clinical Psychology Review* 7: 631-644.

Wortman, C. (1984) Social support and the cancer patient conceptual and methodological issues. *Cancer* 53; May 15 supplement: 2339-2362.

Zinkin, P. and Cox, C. (1979) Child health clinics and inverse care laws: evidence from longitudinal study of 1878 pre-school children. *British Medical Journal* 2: 411-413.

APPENDIX 1

OBSERVATION SCHEDULE (R1)

Clinic:

Date:

		INITIATED BY	
TOPICS DISCUSSED	INFORMATION GIVEN	HV	CLIENT
Duration of interview			
*Referral			
*Leaflets given			

* = questions not reported

APPENDIX 2

CHILD HEALTH CLINIC VISIT QUESTIONNAIRE (R 2)

1. Can you tell me the main reason for your visit for the child health clinic?

2. Were there any other reasons for your visit to the clinic?

3. Did the health visitor give you any information?

No ☐ If no, go straight to question 4

Yes ☐ If yes, answer the following questions then go to question 5

(a) In your opinion what was the **most** important topic that you discussed with the health visitor?

(b) Can you tell me what was important about this to you?

(c) Can you tell me what advice/information the health visitor gave you about this topic?

(d) Did you already know this advice/information before you talked to the health visitor ?

No	☐	Go to question (f)
Yes	☐	Go to question (e)
Some of it	☐	Go to question (e)

(e) As you already knew this information/knew some of this information, can you tell me how you came to be talking about this topic to the health visitor?

(f) Have you used this advice/information since the clinic visit?

No	☐	Go to question (g)
Yes	☐	Go to question (h)
Some of it	☐	Go to question (h)

(g) Will you use this advice/information in the future?

No	☐
Yes	☐
Not sure	☐

(h) Was the advice/information helpful to you?

Very unhelpful	☐
Fairly unhelpful	☐
Neither helpful nor unhelpful	☐
Fairly helpful	☐
Very helpful	☐

Can you tell me in what way it was .... (see above)

(l) Was it important to have this advice/information?

Very unimportant	☐
Fairly unimportant	☐
Neither important nor unimportant	☐
Fairly important	☐
Very important	☐

Can you tell me in what way it was .... (see above)

(j) *Could you have got this advice/information from anywhere else?

Yes ☐ Ask: Can you tell me where else you could have got this information

No ☐ Ask: What do you think would have happened?

Ask: What would you have done next?

(k) Did the health visitor give you advice/information on any other topics?

4 Was it important for you to talk to the health visitor at this clinic visit?

Very unimportant	☐
Fairly unimportant	☐
Neither important nor unimportant	☐
Fairly important	☐
Very important	☐

Can you give me a little more detail about why it was .... (See above)

5 *Did you get any written information at your child clinic visit?

No ☐
Yes ☐ - details:

6 *Was the health visitor you spoke to your named health visitor?

No ☐
Yes ☐

7 Please give me your date of birth

Date of birth ☐☐☐

8 Please give me the date(s) of birth of your children

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐

9 Do you live with a partner or relative?

No ☐
Yes ☐

10 Do you have a paid job?

No ☐ If no, go straight to Question 12
Yes ☐ If yes, ask the following questions and then go to question 12

(a) Do you work full-time or part-time

Full-time ☐
Part-time ☐

(b) What is the name of your job?

11 If you have a partner, do they work?

No ☐ If no, go straight to Question 12
Yes ☐ If yes, ask the following questions

(a) Do they work full-time or part-time

Full-time ☐
Part-time ☐

(b) What is the name of their job?

12 *Do you have any educational qualifications?

No ☐
Yes ☐ If yes, please could you give me some details

14 *Do you have any professional/job qualifications?

No ☐
Yes ☐ If yes, please could you give me some details

15 *Would you like to make any comment on the clinic/health visiting service?

Today's date:

* = questions not reported

APPENDIX 3

HEALTH VISITOR QUESTIONNAIRE - HOME VISITS (HV1)

1 *Initiation of visit

Please tick

health trust guidelines
health visitor assessment

2 *Referral - please describe:

Client - please describe:

***PRE VISIT ASSESSMENT**

3 Specific reasons for visit, please list <u>in order of importance</u>

4 **Client's date of birth** ☐

5 **Does the client (and children) live:** *(Please tick on only)*

Alone ☐
With others ☐

6 **Is the client employed?**

No ☐ Please go to question 7
Yes ☐ Please answer the following questions

a Is the client employed (please tick)

Full-time ☐
Part-time ☐

b What is the name of the client's job?

_____

7 **If the client has a partner, please answer this question, otherwise go to question 8**

Is the partner employed?

No ☐ Please go to question 8
Yes ☐ Please answer the following questions

a Is the client employed (please tick)

Full-time ☐
Part-time ☐

b What is the name of the job?

_____

8 **Dates of birth of children**

1 ☐
2 ☐
3 ☐
4 ☐
5 ☐

9 Length of visit

Please tick	-	less than 10 mins	☐
	-	10 - 15 mins	☐
	-	16 - 29 mins	☐
	-	30 - 59 mins	☐
	-	60 mins or longer	☐

10 Post-visit assessment

	INITIATED BY		
TOPIC DISCUSSED	H/V	CLIENT	*TIME SPENT

Post visit assessment

	INITIATED BY		
TOPIC DISCUSSED	H/V	CLIENT	TIME SPENT

11 *Did you give the client any written information on the topics discussed?

No ☐
Yes ☐

If yes, please give details

12 In your opinion, who was the most of your discussion with during the visit?

Mother alone

Mother and partner

Partner alone

Other

If other, please specify:

_____

SUBSEQUENT ACTION

Please tick

13 *Arrangement for follow-up visit

Referral to other agency *(Please specify below)*

_____

No action

14 *Anticipated next home contact: Approximate month/year

Not known ☐

15 *Could this visit have been carried out at your place of work?

No ☐
Yes ☐

If no, please describe why not

EXCLUDED FROM STUDY

16 Reason

17 Permission obtained for:

Researcher to visit ☐

18 Please put today's date ☐

19 Please say how long it is since your completed the visit

Thank you for completing the questionnaire

Caroline Plews

* = questions not reported

APPENDIX 4

HOME VISIT QUESTIONNAIRE
CLIENT'S VIEW (R3)

1. Can you tell me why the health visitor came to see you?

2. *Did the health visitor carry out any examination or tests during the visit?

   No ☐
   Yes ☐ If yes, please describe

3 Can you tell me if the health visitor gave you any advice or information?

   No ☐
   Yes ☐ If yes, I would like to ask you some questions about this advice/information

(a) Can you tell me in your opinion what was the most important topic that you discussed?

(b) Can you tell me what was important about this to you?

(c) Can you tell me what advice or information the health visitor gave you about this topic?

(d) Did you already know this advice/information before you talked to the health visitor?

No	☐		Go to question (f)
Yes	☐	)	Ask question (e)
Some of it	☐	)	

(e) As you already knew this information/knew some of this information, can you tell me how you came to be talking about this topic to the health visitor?

(f) Have you used this advice/information since the visit?

No	☐	Go to question (g)
Yes	☐	Go to question (h)
Some of it	☐	Go to question (h)

(g) Will you use this advice/information in the future?

No	☐
Yes	☐
Not sure	☐

(h) Was the advice/information helpful to you?

Very unhelpful	☐
Fairly unhelpful	☐
Neither helpful nor unhelpful	☐
Fairly helpful	☐
Very helpful	☐

Can you tell me why it was ..... (see above)

(i) Was it important for you to have this advice/information?

Very unimportant	☐
Fairly unimportant	☐
Neither important nor unimportant	☐
Fairly important	☐
Very important	☐

Can you tell me why it was ..... (see above)

(j) *Could you have got this advice/information from somewhere else?

Yes ☐ Ask: Can you tell me where else you could have got this advice/information?

No ☐ Ask: What do you think would have happened?

Ask: What would you have done next?

(k) Did the Health visitor give any information on any other topics?

No ☐ If No, go to question 4.
Yes ☐ If Yes ask the following question

Please list the other topics that you discussed with the health visitor.

4. Other than advice/information, did the health visitor give 'support' to you in any way during the visit?

No ☐ If No go to question 5

Yes ☐ If Yes - ask the following questions

Can you describe what this 'support meant' to you?

Prompt: did you feel different/better in any way after the health visitor had been?(You may not have felt any different or better)

Can you tell me whether you could have got this 'support' elsewhere?

*Was this important to you?

Very unimportant	☐
Fairly unimportant	☐
Neither important nor unimportant	☐
Fairly important	☐
Very important	☐

5. *Are you satisfied with this visit from the health visitor?

Very unsatisfied	☐
Fairly unsatisfied	☐
Neither satisfied nor unsatisfied	☐
Fairly satisfied	☐
Very satisfied	☐

6. *Are you usually satisfied with you visit from the health visitor?

Very unsatisfied	☐
Fairly unsatisfied	☐
Neither satisfied nor unsatisfied	☐
Fairly satisfied	☐
Very satisfied	☐

7. Would you have attended a health centre or surgery for this appointment with the health visitor?

If no, please say why not.

*Did the health visitor give you any written information?

No ☐
Yes ☐

If yes, please specify

9. *Is there any other comment you would like to make about the health visiting service?

Today's date: ☐

* = questions not reported

APPENDIX 5 (C1)

Dear Client

Clinic Information

My name is Caroline Plews and I am a researcher based in the Department of Nursing at Hull University. I am hoping very much to be able to enlist your help in a survey of health visiting activity I will be carrying out at several baby clinics in the X area over the next 3 months. I expect to visit this clinic about 4 times up to Christmas. I will be looking at what health visitors do and am very interested in trying to find out what clients think about the service that is provided. This work is being done with the permission of the health visitors. To do this I need to observe the health visitors talking to some clients.

Anything that you say to the health visitor will be treated strictly confidentially. If you would prefer me not to be present this is not a problem, please just let me or your health visitor know. As well as sitting with the health visitor, I also hope to be asking some of the people who come to the clinic if I can visit them at home to ask their views about the clinic service (this would be completely confidential) . The visit would take about 30 minutes and be at a time to suit you. * *To make it easier to record what people tell me I would like to use a tape recorder during the home interview, although I would not use one if people are uncomfortable with this.* I do hope that I can get as many people interested as possible. It is really important to get as many clients' opinions and ideas as I can to allow me to get a fair idea about how local people see and use their clinic. Once again, if you do not want to be involved please free to say no.

Please ask me if there is anything else you would like to know about the project. I can also be contacted at the Department of Nursing on 466351.

Thankyou for taking the time to read this information.

Caroline Plews

* taping was not carried out in the pilot study therefore this section was omitted from the pilot information sheet

APPENDIX 6 (C2)

AGREEMENT TO PARTICIPATE IN A RESEARCH PROJECT

As explained to you, this study is investigating what people think about their baby clinic service. I hope that the information we find out will help improve the services that are offered.

I would like to visit you at home to fill in a brief questionnaire asking some details about your visit to the clinic. Any information given to me will be confidential and only used for the purpose of the research. I do hope you will be able to help us by taking part in the study, since the wider an impression we get of people's ideas and opinion the better we will be able to improve the service we offer.

You are quite free to refuse the home visit if you change your mind at a later date.

**To make it easier to record all the information, Caroline would like to tape your discussion, and will ask you for your consent to this when she visits. However, a tape recorder will not be used if you do not wish this. Once again, if you agree to go ahead and be taped, you are free to change your mind at any time during the interview. All tapes will be confidential and will be destroyed at the end of the study.*

I agree that Caroline Plews has explained the study and give permission to her to visit me at home for the purpose of filling in a questionnaire. I understand that signing this form does not in any way affect my right to refuse the visit at a later date if I so choose.

NAME: _____ **DATE:**

SIGNATURE: _____

I have explained the study:

NAME: Caroline Plews **DATE:**

SIGNATURE: _____

* taping was not carried out in the pilot study therefore this section was omitted from the pilot consent forms

APPENDIX 7 (C3)

AGREEMENT TO PARTICIPATE IN A RESEARCH PROJECT

As explained by the health visitor this study is investigating what people think about the health visiting service. I hope that the information that we find out will help improve the services that are offered.

I would like to visit you at home to fill in a brief questionnaire asking some details of the visit by your health visitor.

Any information given to me will be confidential and only used for the purpose of the research. I do hope you will be able to help us by taking part in the study, since the wider an impression we get of people's ideas and opinion the better we will be able to improve the service we offer.

You are quite free to refuse the home visit if you change your mind at a later date.

**To make it easier to record all the information, Caroline would like to tape your discussion, and will ask you for your consent to this when she visits. However, a tape recorder will not be used if you do not wish this. Once again, if you agree to go ahead and be taped, you are free to change your mind at any time during the interview. All tapes will be confidential and will be destroyed at the end of the study.*

I agree that _____ has explained the study and give permission for Caroline Plews to visit me at home for the purpose of filling in a questionnaire. I consent to my health visitor giving details from my records for the purpose of research. I understand that this information will not be identified by name and treated confidentially. I understand that signing this form does not in any way affect my right to refuse the visit at a later date if I so choose.

NAME: _____ **DATE:**

SIGNATURE: _____

I have explained the study:

NAME: _____ **DATE:**

SIGNATURE: _____

* *taping was not carried out in the pilot study therefore this section was omitted from the pilot consent forms*

APPENDIX 8 (C4)

AGREEMENT TO PARTICIPATE IN AUDIOTAPING

To make it easier to record all the information, I would like to tape our discussion on audiotape. This is to help me remember what we have said and to lessen the distraction of note-taking. If you agree to go ahead and be taped, you are free to change your mind at any time during the interview. All tapes will be confidential and will be destroyed at the end of the study.

I agree to audiotaping of our conversation. I understand that I can change my mind at any time during the conversation, and that audiotaping will then stop. I understand that audiotapes will be destroyed at the end of the study:

NAME: _____ **DATE:**

SIGNATURE: _____